

**Integrating Psychiatry and Primary Care**  
*Series Editors:* Dinesh Bhugra · Michelle B. Riba

**Mary Jo Fitz-Gerald**  
**Junji Takeshita** *Editors*

# Models of Emergency Psychiatric Services That Work



WORLD PSYCHIATRIC ASSOCIATION



Springer

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# **Integrating Psychiatry and Primary Care**

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Mary Jo Fitz-Gerald • Junji Takeshita  
Editors

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*For our families*

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# Introduction: Models of Psychiatric Emergency Services That Work

In November 2015, members of the Academy of Psychosomatic Medicine (now called Academy of Consultation-Liaison Psychiatry) Special Interest Group in Emergency Psychiatry and the American Association for Emergency Psychiatry jointly sponsored a 4-h workshop at the Academy of Psychosomatic Medicine annual meeting called “Taming Your Tiger: Approaches to Emergency Psychiatry That Work.” The speakers decided that the information could be translated into a book for those who are interested in, work for, or administer emergency services to the mentally ill. With the support of Springer Publishing, the authors searched for additional input from leaders in the field on an international level. Our hope was that the busy emergency practitioner could reach for the book when suggesting a different system of care to administration, weigh the pros and cons of each, and arrive at an intelligent decision for that specific hospital system or community. The chapters are designed to be brief and easy to read, so that one can glance through the table of contents for alternatives.

This manual has three sections. The first examines different models of care, advantages and disadvantages, and specific requirements for each model. The editors soon realized that there were a myriad of different types of emergency psychiatric services; there were some models that seemed more common or had more research evidence. Some services had different names or overlapped with other units. We chose to focus on the services that seemed more prevalent or had a greater body of research with the knowledge that psychiatric emergency services change on a regular basis, and the book was not all inclusive.

The second section details various aspects of any emergency setting which deal with the mentally ill. The chapters range from physical requirements, to financial and legal aspects, and to security. The third section examines the models of emergency care on an international level: Canada, Europe, and Asia.

We hope that you will find the tools you need to develop a new system of emergency psychiatric care or improve the structure of an existing model. Our goal is to improve patient care and provider morale with improvements in workflow.

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## **Part I**

# **Models of Emergency Psychiatry Care**



# Models of Emergency Psychiatric Care

1

Yee Xiong and J. J. Rasimas

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## Abstract

Decreases in hospital and residential treatment services coupled with an increase in the general population and its mental illness burden have created a public health crisis in emergency psychiatry. Various emergency mental healthcare models exist in different communities. Some reflect longstanding methods of consultation, others have launched innovative approaches to the changing landscape, and some have emergency departments functioning with minimal expertise as problems increase. The best solutions will anticipate the needs of a given

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community, mobilize multidisciplinary resources, and integrate systems of care all while attending to the unique aspects of mental health conditions and the patients who suffer them.

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## 1.1 Introduction

The Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) requires hospital emergency departments (EDs) to accept and stabilize all patients who walk through their doors regardless of ability to pay. As the population grows, so does the need to access emergency psychiatric and medical services. ED visits related to mental health or substance use increased over 40% from 2006 to 2014 [1] and continue to grow with an estimated annual rate of 21 visits per 1000 adults [2].

Efforts to reduce and ultimately close state psychiatric facilities and cut costs associated with community supports have contributed to the increasing number and complexity of psychiatric emergencies. In the United States, 80% of psychiatric beds were provided by state or county mental hospitals in 1970. The number of psychiatric beds decreased by almost 60% by 2002, and the private sector funded over 68% of inpatient capacity [3]. As a result, models of psychiatric emergency service (PES) were developed to address the growing need for clinicians and services for patients with emergent mental health decompensation. However, there exists a paucity of evidence to guide best practices and organizational structure of a comprehensive PES [4]. In the United States, the role of EDs has expanded to function as the gateway to healthcare access and as a safety net for the community it serves—for mental health and for physical conditions [5]. Sometimes emergency mental health services represent little more than such a gateway, and robust crisis intervention and treatment delivery are essential now that the public health need has grown while the accessibility of other services has diminished. The structure of a PES is dictated largely by the needs of the community it serves. Key factors include service utilization and costs, facility size, and the access to inpatient psychiatric services within the facility or community [4].

The challenges of a growing population of complex emergent psychiatric needs force the evolution of its scope of practice. Psychiatric emergencies can happen in any place and time without prior assessment or planning and often include a variety of clinical presentations and diagnoses. Additionally, patients with emergency mental health visits often present with altered mental status compared to baseline due to various reasons, such as behavioral health decompensation, baseline cognitive dysfunction, recent substance use, etc., that limits the ability to obtain a thorough diagnostic assessment. Individuals with altered mental status require a more extensive evaluation, treatment, and stabilization in the ED [6] than medical ED visits with coherent patients with intact capacity. As a reflection of the capricious presentation of mental illness, emergency psychiatric clinicians are expected to have the core skills for psychiatric practice in attending to the care, safety, stabilization, and assessment of patients in a time of psychiatric crisis, as well as more specialized

practical abilities [7]. The modern practice of a comprehensive PES includes components of triage, medicolegal assessment and treatment, consultation, community education, crisis prevention, disaster coordination, referral, and short-term care coordination [8].

Unfortunately, emergency psychiatry needs frequently outpace the available resources. Many limiting factors have been reported, including capacity for psychiatric inpatient admissions, duration of inpatient hospitalization, community resources to prevent crises, basic access to healthcare, and health insurance for longitudinal care [9]. These mismatches can lead to mishandling psychiatric emergencies and exacerbate patients' presenting psychiatric concerns. The issues are further intensified by the national shortage of psychiatrists that results in the rationing of mental health services only to individuals with the most severe psychiatric illnesses—a kind of “crisis only” model that converges acutely on EDs [10].

When the volume of patients waiting in the ED exceeds those discharging from the ED, patients are backed into a holding situation known as ED “boarding.” Boarded patients are those who have been marked for admission to an inpatient psychiatric unit in the hospital or another one in the region, but continue to wait in the ED for a bed to become available. Boarding is a major cause of ED crowding that impedes access to care for acutely ill patients of all types, not just those in psychiatric crisis [11]. A mental health patient's length of stay in the ED is dictated largely by boarding time, even after controlling for other factors known to affect the length of stay in the ED. In general, admitted and transferred patients experience longer delays, and thus length of stay, than discharged patients [12]. And unfortunately, many patients with lower presenting acuity are discharged because of a pre-defined triage allocation algorithm in the ED, not as a consequence of having received formal treatment at the level of the ED that directly addresses their needs and alters their clinical course. A major determination for visits to an ED setting is the lack of access to psychiatric services [10], and after long wait times, the result may simply amount to a referral.

There is no one-size-fits-all healthcare system fix to address crowding and boarding problems. In the United States, the delivery of emergency mental health services began in the 1920s when psychiatry residents in training worked in medical emergency rooms to manage emergency behavioral health crises. Dedicated services to address mental illnesses developed much later, after the passage of the Community Mental Health Services Act of 1963. This permitted the shifting of some psychiatric emergency care from the EDs to less restrictive community-based alternatives [13]. Funding has been channeled to develop various services with community-based providers and intermediate care services, such as supportive housing, partial hospitalization, intensive outpatient case management, assertive community treatment, dialectical behavioral therapy, recovery-based treatment centers, intensive residential treatment services, and crisis stabilization centers [8]. Between 1986 and 2014, mental health expenditures paid for outpatient treatment increased; however, expenditures decreased in other areas including in inpatient care and residential treatment [14]. The American Psychiatric Association (APA) Task Force on Psychiatric Emergency Services acknowledges the limitations of the psychiatric services

available for emergency crises and urges for PES to be designed and categorized as unique treatment facilities [15].

The APA Task Force on Emergency Psychiatric Services categorizes PES in two broad categories: hospital based and community based. These can be subdivided into two approaches to providing services, resident and ambulatory/mobile, and two levels of access, emergent or urgent [15]. This chapter will provide a foundation and introduction to models of emergency mental health services with detailed discussions to follow that build practice and care upon those models throughout the remainder of the book.

---

## 1.2 Hospital-Based PES

Hospital-based PES typically falls into one of two models: a consultation service to the general ED or medical/surgical unit or an ED-based specialized mental health unit (located in the ED or in a stand-alone facility nearby). In some systems, there is a hybrid of the two models: a consulting psychiatrist is mobilized whenever another provider asks for help with a patient. The model of deploying a psychiatric consultant physician to the ED was the foundation for addressing behavioral and psychiatric emergencies in the 1980s in the United States [16]. According to the Academy of Consultation-Liaison Psychiatry's Psychosomatic Medicine Practice Guidelines, the aims of psychiatric consultation entail gathering the appropriate information to promptly evaluate the patient, assess safety, establish a differential diagnosis, and initiate a treatment plan [17]. The exact conduct and methodology of consult services have varied and developed over the years. More recently, telemedicine (via live, interactive videoconferencing) has provided patients with readily available and confidential access to healthcare, including emergency psychiatric assessment and treatment. Telepsychiatry has been shown to be effective and safe in selected populations [18–21]. However, the use of videoconferencing to evaluate emergent psychiatric crises has raised complicated standard-of-care issues for a variety of complex presentations that has yet to be addressed in the literature [22].

The American Association for Emergency Psychiatry has advocated for treatment, rather than mere triage, in emergency settings, which calls for trained providers to be available on a 24/7 basis to perform assessment, treatment planning, and actual provision of care [23]. In response to the overwhelming shortage of human resources for psychiatric health, alternative approaches to the delivery of mental health interventions have been explored. Mid-level practitioners or advanced practice providers (APPs), such as nurse practitioners (NPs), advanced practice registered nurses (APRNs), and physician assistants (PAs), are potential solutions to workforce and provider-access gap. In the United States, APPs were initially introduced to address the geographic and specialty maldistribution of physicians and primary care services in the mid-1960s. APPs function similarly to a physician in the diagnosis and possibly treatment of ailments depending on their scope of practice defined by the state's licensing requirements [24–26]. Now the services that APPs provide have expanded to other specialties, including critical care, surgery, dermatology, occupational

medicine, psychiatry, addiction medicine, and more [27]. Efforts to task-shift to APPs and upgrade their skills to take on psychiatric caseloads may assist in the shortage of human resources in behavioral healthcare [28]. In an emergency psychiatry setting, the goal is often to have access to a behavioral health team consisting of a psychiatrist, psychiatric APRN or PA trained in psychiatry, and an independently licensed mental health professional [e.g., master's in social work (MSW), Ph.D. clinical psychologist, or licensed mental health clinician (LMHC)]. A dilemma of incorporating nonphysician providers is their varying academic backgrounds and clinical care experience. The training of PAs is modeled on a medical school curriculum with clinical rotations in various specialties, whereas NPs are typically trained in one specialty [29]. An integrative/collaborative behavioral healthcare model can assign varying degrees of involvement in the management of the psychiatric emergencies depending on the demands of a particular case, skills of specific providers, and the capacity of the healthcare setting and its team [30].

As an alternative to mobilizing multidisciplinary expertise to work in the general ED on behalf of patients in crisis, an ED space dedicated to PES may help improve the delivery of care in psychiatric emergencies. Such a model offers more privacy for patients with mental illness while simultaneously mitigating disruptions to other ED staff and patients and the flow and function of the general milieu [31]. Furthermore, there are benefits in the timeliness of psychiatric evaluation and assessment, emergency medication, seclusion/restraint, and elopement seen in an ED PES compared to the model of the psychiatric consultant to the ED [16]. A dedicated PES that is distinct from the medical ED offers a secure environment to allow the staff to observe the patients and initiate psychiatric treatment promptly and more effectively. Rather than having to conform to workflow expectations and the rapid interactive rhythms of a general ED, staff can be more attuned to the unique needs of mental health patients and better adapt routines to those with significant psychobehavioral impairments. Emergency nurses may not feel competently prepared to manage mental health patients in the emergency setting [31]. Often the ED PES unit has dedicated staffs trained to address this limitation. Also, the unit includes security personnel who understand mental health issues and can appropriately maintain a safe environment for patients with mental health problems and staff [15]. This alternative is desirable because restraining patients can adversely impact their care and result in additional resource use with longer ED lengths of stay; restrained patients spend an additional 4.2 h in the ED compared with those not physically restrained [32]. One study demonstrated a 39% reduction in the rate of seclusion and restraint when intervening with a team of personnel trained to respond to behavioral emergencies and adequate video surveillance monitoring in a dedicated PES setting [33]. Such a psychiatric emergency response team focuses on optimizing the use of verbal de-escalation techniques to defuse crisis situations. A safe and secure healthcare environment that promotes patient dignity and autonomy may nearly eradicate the use of seclusion and restraint and ultimately save money while simultaneously improving patient outcomes and staff working conditions [34].

Both a dedicated PES and the consultation service provide necessary diagnostic assessments, treatments, and hospital admission or referral to follow-up



appointments [35]. The volume of patients and available financial, hospital, and staffing resources usually determine the type of service offered within a specific hospital. Hospitals with a dedicated ED PES unit usually have over 3000 emergency psychiatry encounters annually [15]. A cross-sectional survey of hospitals showed that about 45% have in-house PES, 41% contract with mental health providers/groups in the community, and 14% do not provide PES at all [4]. The function and responsibility of the attending psychiatrists staffing a PES can range from on-call telephone availability offsite to 24/7 mandatory in-house coverage [15].

---

### 1.3 Regional Dedicated Emergency Psychiatric Facility

Another PES delivery system is a dedicated emergency psychiatric facility for a region which serves to evaluate and treat the majority of mental health patients for a given catchment area. Such facilities accept patients in direct self-referral, from emergency services and law enforcement officials whose initial assessment suggests a primary mental health problem, and in transfer from other EDs in the region. This latter mechanism is legally in accordance with EMTALA, because such facilities provide a specialized level of care that is measurably different from what is available within the general EDs in their referral networks. Prompt access to treatment in one such model involving full 24/7 staffing with psychiatrists and dedicated staff has been shown to reduce boarding times for patients awaiting psychiatric care and improved rates of stabilization of mental health crises without inpatient psychiatric admission [36]. A dedicated PES facility with the capacity to accommodate for extended observation can markedly reduce the rates of expendable psychiatric inpatient admission from 52% to 36% [37]. The integrated emergency treatments they offer—psychopharmacological, psychological, and social—allow some patients to avoid, rather than merely delay, admission to a psychiatric inpatient unit, thus reducing resource utilization and simultaneously alleviating boarding in nearby general EDs [38]. Such independent facilities can also strive for even higher standards of humane and attuned care for individuals in mental health crisis. In order to be successfully launched with sustained effectiveness, such facilities must have physician leadership adept at coordination with a vast array of entities including general hospitals, EDs, inpatient psychiatric facilities, outpatient psychiatric providers and teams, emergency response personnel, law enforcement, and even local political and community stakeholders.

---

### 1.4 Community-Based PES

A crisis residence (CR) is a 24-h emergency psychiatric care space outside of the hospital setting – often an apartment complex, a group home or foster home, or even an individual's own home. There are three levels of care: acute diversion, crisis residence, and crisis respite. Acute diversion programs may take in patients from emergency services as a somewhat less restrictive alternative to hospitalization, but

function similarly to voluntary hospitalization with full-time professional and paraprofessional practitioners capable of delivering milieu, group, and individual psychosocial treatments supported by availability of psychiatric consultants who can add diagnostic and pharmacologic expertise. A crisis residence provides care to patients with moderately acute psychopathology in a safe, supportive environment (either constructed or renovated for the purpose) staffed by social workers and housing counselors. Medication-based interventions may be less available, but staff frequently assist those who stay in such facilities for several days to connect to appointments with outpatient psychiatric and chemical dependency providers. Respite programs deliver care to patients with housing disruptions and typically have staff members with less advanced mental health training. However, they do frequently coordinate with social services to help connect their clients to the care they need in the community. Such programs may offer mobile response, which provides service to the broader community and flexibility to go wherever referrals require, while simultaneously reducing the need for psychiatric inpatient admissions [13]. Independent of the level of care needed, these CR services do not provide appropriately trained or adequate staffing and infrastructure to prevent elopement or manage the violent or seriously suicidal patient [15].

---

## 1.5 Systems Integration and Crisis Prevention

Users of PES designed with a community orientation offering outpatient crisis intervention are more satisfied than users of mental health services who used hospital-based facilities during emergencies [39]. Additionally, crisis-oriented ambulatory psychiatric services permit rapid access to high-intensity services while subsequently establishing care in an ambulatory setting [40]. For instance, coupling an open access clinic schedule to crisis programs with dedicated appointment slots can help to ensure that clinic hours are actually utilized (e.g., decrease no-show rates through acute case management) and connect patients to ongoing care in the community and maintain the continuum of care [15]. These programs offer the ability to intervene and reduce avoidable visits to hospitals while delivering a higher level of patient satisfaction. For people who do not require acutely emergent intervention, urgent care provides stabilization in a more cost-effective manner than an ED while connecting the patient to the appropriate longitudinal care. Still, access to those community connections is limited in many areas. Recent data show that the rate of mental health-related physician office visits to psychiatrists is almost twice as high as the rate of visits to primary care physicians overall according to the National Ambulatory Medical Care Survey [41]. With increases in care seeking, a strategy for meeting mental health needs must include increasing the capacity of primary care to respond to these issues supported by co-location of behavioral and physical health services. Such integrated models demonstrate improved identification of psychiatric problems, better mental health outcomes, and enhanced provider satisfaction over traditional models of referral with the need to coordinate care at a distance [42]. Having a medical and psychiatric “home” delivers better continuity

through the many disciplines available to assist in integrated settings and makes it less likely that patients will suffer psychiatric emergencies in the first place.

---

## 1.6 Comprehensive Psychiatric Emergency Program

Few organizations throughout the United States have implemented a systematically organized psychiatric emergency services inclusive of 24/7 crisis intervention services in the hospital ED, hospital-based observations beds, community-based crisis outreach services, and temporary community-based crisis residence services. In 2012, there were 19 licensed facilities in New York that worked together in this innovative model for a Comprehensive Psychiatric Emergency Program (CPEP). Reports from CPEP facilities show decreased length of stay in the CPEP ED with timely triage and access to a physician to address psychiatric crises. Additionally, the CPEP model prevents inappropriate hospital admissions as it offers more flexibility in discharge planning, both in a hospital-based setting and a community-based setting [43].

---

## 1.7 Summary

The APA Task Force on Psychiatric Emergency Services notes that urgent psychiatric services bridge the gaps between acute and ambulatory care services [15]. The remainder of this book will address the liabilities, capabilities, and limitations of PES models employed in the United States and internationally with guidance on factors to consider when implementing models of PES. Regardless of the model chosen for a given health system and its surrounding community, setting it up with connections to ongoing outpatient care is essential in a field where the majority of illness have a longitudinal course. Expecting definitive care from emergency encounters, even if they are handled in consistently compassionate and sophisticated fashion, is unrealistic for the public health needs involved.

---

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# Business as Usual: Emergency Rooms with No Psychiatric Coverage at All

2

Felix Geller

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## Abstract

Today's emergency department (ED) is tasked with rapidly stabilizing emergent and life-threatening physical conditions and is the gateway to higher levels of inpatient care for most specialties, including psychiatry. Though designed to be an efficient and versatile unit, the ED faces increased challenges when providing emergency care for psychiatric patients. The standard being adopted for psychiatric crisis assessment is a specifically dedicated unit with an appropriate environment and staff modifications for mental health emergencies. Such units are still rare and are usually located in large hospitals or university centers. The more common model in place in most EDs is to set aside specific beds or sections

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within the general emergency room setting. These sections or beds are designated for patients presenting with psychiatric emergencies or conditions and are selected so that these patients can be easily monitored. This chapter outlines the capabilities and limitations of an ED system to deliver emergent psychiatric services when no psychiatric specialists are available.

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## 2.1 Introduction

The general emergency department (ED) is tasked with the treatment of emergency patients, including those requiring psychiatric care. The emerging standard for the assessment of psychiatric emergencies is through a dedicated emergency psychiatric unit, often called a crisis unit. These units, and the professionals that staff them, can provide assessments and services that were limited under previous models. While dedicated psychiatric emergency services are the preferred treatment for those in psychiatric crisis, there are still many emergency departments without access to psychiatric consultation. This chapter will focus on the limitations and capabilities of an ED system without access to a psychiatrist.

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## 2.2 Limitations and Capabilities of This System

The deinstitutionalization of psychiatry in the United States in the latter half of the twentieth century aimed to maximize patients' freedom while providing comprehensive services at the community level. Unfortunately, the demand for mental health treatment quickly exceeded the available resources. This shortage of community staff has, by default, forced local hospitals to care for a large number of psychiatric patients, with the emergency department (ED) most often being the first place of contact for a crisis [1]. In response, emergency medicine specialists have begun to develop methodologies and procedures aimed at rapidly triaging, stabilizing, and dispositioning these individuals [2]; however, progress in emergency psychiatry is still hindered by the internal and external limitations of the system.

Historically, the ED's physical structure has been optimized for medical and surgical emergencies, not psychiatric care. Patients in crisis benefit from dedicated units that allow for privacy, observation, safe equipment and furniture, and a dedicated multidisciplinary staff [3]. While this is an ideal model of care, for most hospitals and medical centers the ideal is often not feasible. This approach requires both heavy start-up costs and ongoing funding [4] that is simply not available. Without these dedicated units, hospitals attempt to address psychiatric emergencies by providing space within the emergency room itself. However, studies have shown that factors such as overcrowding, lack of privacy, and increased noise levels limit efficacy, as patients may be reluctant to engage in a setting without confidentiality; therefore, this lack of patient engagement increases length of stay and decreases treatment efficacy and satisfaction [5].



Similarly, staffing and time constraints continuously hamper the emergency department's ability to perform comprehensive mental health evaluations, forcing the ED staff to be conservative with discharge. Although emergency clinicians are well-trained to quickly assess and stabilize an individual using objective measures, diagnostic tests, and physical examinations, psychiatric patients, especially those at elevated risk for suicide, rarely allow for such standard evaluations. These patients require extensive time for the interview alone and EDs without a dedicated psychiatric care unit do not have the time or staffing to dedicate to thorough evaluations.

Suicide rates have increased over 60% in the last century and suicide is now the second leading cause of death for patients between the ages of 10–34 years old [6]. Persons completing suicide frequently contacted clinicians in both the year and month before attempting or completing the act [6]. Despite the increased availability of risk assessment measures such as the Columbia-Suicide Severity Rating Scale (C-SSRS), there is little evidence to support the accurate prediction of an acute suicide attempt or completion using screening tools alone [7]. Therefore, current evaluations of suicidal patients rely on accurate histories, historical records, collateral information, and knowledge of the patient, which in turn requires extensive interactions and clinician presence. Emergency rooms without dedicated psychiatric staff have limited ability to evaluate individuals with mental health diagnoses despite often being the place of longitudinal care to such patients. As a result, many clinicians will err on the side of caution and admit the patient [8] or needlessly attempt to transfer the patient to a psychiatric facility, resulting in a prolonged stay in an emergency room awaiting a psychiatric bed, commonly referred to as “boarding.”

Despite these limitations, ED personnel are still key in the treatment of psychiatric emergencies and, as previously described, are frequently the only providers available to perform the psychiatric assessment. In response to this recognized need, emergency training programs around the country are beginning to incorporate psychiatric rotations into their curriculum [9].

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## 2.3 Personnel and Staffing Needed

Common presentations to the emergency room include suicidal ideation, psychoses, mania, agitation, intoxication, and patients who have been recently arrested or who are currently incarcerated. These conditions require care that may include a line-of-sight observation level, self-harm resistant equipment, trained staff, sitters, and (frequently) security or law enforcement personnel. Although research shows that the availability of psychiatrists in the emergency room, either on site or through telemedicine, has the ability to increase the efficiency of care [10], the integration of specialized mental health professionals within the general ED is a relatively new concept.

Appropriate staff levels is also an important consideration. Hospital staffing ratios are often based on the number of current patients. For instance, California enacted legislation that limits each ED nurse to about four patients in the general ED and each psychiatric inpatient unit nurse to six patients [11]; however, the



current consensus is that emergency rooms need to staff units according to patient severity, not the number of patients [11]. A reliable and effective method to do this has yet to be universally adopted. Other healthcare professionals such as social workers and discharge coordinators are required for these units to help enroll discharged patients in community care programs, but the presence of these individuals is usually limited in general emergency rooms.

Psychiatric patients also require staff that are familiar with their medication regimens and interactions. Despite the growing trend toward single agent treatment, many psychiatric patients are still on polypharmacy regimens. Moreover, patients with severe and persistent mental illness are at an increased risk for other medical comorbidities and are also prescribed medications for these conditions. The patients themselves may be poor historians as well as poorly or even noncompliant with these regimens. This factor further complicates ED care and potentially contributes to the ED having the highest rates of medication errors among all departments [12]. In response, pharmacists are now incorporated into the emergency care of psychiatric patients in larger centers, where they assist with contacting patients' families and pharmacies to help ensure adequate medication reconciliation. Furthermore, ED pharmacists are able to assist with the transition to an inpatient unit so that the receiving facility pharmacy can obtain non-formulary medications [13]. Pharmacists may also assist with follow-up treatment, including prior authorization and patient assistance programs. These professionals have shown the ability to reduce medication delays and omissions; however, despite studies demonstrating that pharmacists in the ED both improve care and decrease costs [12], their presence in the emergency rooms outside of dedicated units and university centers remains scarce.

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## 2.4 Patient and Staff Safety Concerns

The emergency room is a bright, fast-paced environment, where intoxicated or agitated individuals require observation prior to staff making decisions about their disposition. As the gateway to hospital treatment, disease severity is often at its worst, leading to agitation, frustration, and violence, especially against nurses [14]. Unfortunately, angry outbursts, confusion, and disruptive behavior are now seen as frequent events, which raise the question of the need for restraints even though it's understood that the use of physical restraints delays inpatient admissions and negatively impacts patient care [4, 15]. Prophylactic oral medications, especially atypical antipsychotic agents, have reduced the need for physical restraints [15], but they are not usually readily available in a general ED without a psychiatric crisis unit on site. The lack of availability has led ED staff to use other agents that can also lead to delayed care [4].

Early recognition and management of agitation is crucial to minimizing harm to patients and staff [15]. At the Kennedy University Hospital system in New Jersey, a specific procedure was developed to identify pending violence and provide early intervention. When this procedure was implemented, the number and intensity of episodes decreased significantly [16]. This approach involved interdisciplinary

training and cooperation among psychiatric staff, security, nurses, physicians, and pharmacists. The main components of the procedure focused on regular patient interaction, observation of body language, having the patient within the line of sight, and addressing the concerns of relatives [16]. Although labor intensive and reliant on staff retention, the decrease in violence led to its use throughout that hospital system. Fortunately, this approach is now widespread among other hospital organizations, with individual entity refinement in accordance with internal metrics.

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## 2.5 Collaboration Needed

Effective psychiatric care requires multidisciplinary collaboration between various settings. Most individuals prefer outpatient care, but afflicted individuals often minimize their psychiatric symptoms until emergency services are required. Still, even after crisis stabilization, the success of any treatment plan lies in aftercare, which requires access to community resources and follow-up appointments. Unfortunately, many EDs may not have access to aftercare referral resources.

The primary level of cooperation is usually community-based between family, social services, and law enforcement. At first, community programs were primarily aimed at destigmatizing mental illness, but they are now beginning to take on an education component. Mental health first aid programs instruct community members on recognizing symptoms, causes, treatments, and responses to crisis situations [17]. There are also support communities throughout the country, including the National Alliance on Mental Illness (NAMI), Alcoholics Anonymous, Al-Anon, and other similar groups. Individuals from these groups or communities tend to have frequent contact with patients and are often the ones that bring them to clinical attention, making their collateral information invaluable, especially for risk assessment.

At the professional level, law enforcement services are frequently utilized to enable treatment. Police presence is required by crisis teams in the community, and law enforcement officers are usually the first professionals on the scene of a mental health crisis. They help to stabilize volatile situations, provide safety to medical professionals in the field, and tend to have more frequent interactions with the patient than clinical staff. In addition, police officers are often instrumental for continuity of care, as their contact can link the patient to treatment. In fact, the chances of a patient being engaged in continuous mental healthcare increase significantly when police officers either bring the patient to the crisis center or contact that individual's provider [18].

At the hospital level, various physicians, nurses, and administrators must coordinate efforts to provide efficient treatment. Psychiatric inpatient units tend to require "medical clearance" of a patient prior to accepting the transfer; however, medical clearance has no concrete standards, often delays care, and forces unnecessary laboratory testing [19]. A newer proposed concept is that of medical stability, meaning that the patient's health is sufficiently stable such that they can be admitted to a psychiatric unit where a full medical evaluation and further consultations, such as

neurology and physical or occupational therapy, can be obtained. This approach appears to be more suitable to standardization which, in turn, can improve the efficiency of treatment, but still requires the close cooperation of different professionals to streamline patient disposition. In Sutter and Yuba counties in California, a team of emergency physicians, telepsychiatrists, and county mental health professionals in the emergency room cooperatively evaluate the patient, then design, and implement a treatment plan with follow-up and aftercare. This project has shown a reduction of wait time and ER boarding, as well as enhancing cooperation between the various staff disciplines [20]. Without psychiatric coverage, multiple studies have shown that many of the patients would be boarded in the ED, leading to overcrowding and interference in care [4].

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## 2.6 Expertise Needed

Traditionally, much of the focus on mental health in the ED is about safety and risk assessment, but recently, more attention has been paid to aftercare. One of the primary jobs of emergency staff is to evaluate and determine whether an individual poses a risk to themselves or others; however, accurate suicide risk evaluation depends on the information provided by the patient as well as the objective signs and available history. The emergency clinician requires extensive training and experience to recognize the verbal and nonverbal language that is essential to psychiatric assessment [10]. Furthermore, mental healthcare tends to be split between pediatric and adult patients with few individuals treating both populations. As outpatient mental health is limited, especially for minors, emergency rooms have become the resource center for access to child psychiatry with at least 2–5% of all pediatric ED visits related to mental health, an amount that is on the rise in rural areas [5]. Since only a small number of emergency rooms have access to a child psychiatrist, psychiatric boarding of children has become more common and results in a length of stay that is typically twice as long as the stay for children with nonpsychiatric complaints [5].

Currently, the United States has been experiencing an increase in substance use disorders, especially opioids. Nevertheless, other substances (e.g., alcohol, stimulants, benzodiazepines and other sedatives, and novel psychoactive substances) also require emergency medical attention. The emergency department is often involved with such patients, particularly during detoxification. This situation offers a unique opportunity for psychiatrically staffed EDs to initiate medication-assisted treatment (MAT) to these patients, as their frequent ED use often comes at a time of distress and high motivation for change [21]. Until recently, emergency room personnel were hesitant to initiate MAT for patients with substance use disorders due to concerns about follow-up; however, studies now show that initiating MAT in the emergency room is not associated with greater dropout rates in aftercare than when initiated in more traditional settings [21, 22].

One such example is the initiation of buprenorphine by emergency room personnel. The abuse of prescription opioids and heroin continues to be a major public

health concern in the United States. These patients often spend their time and resources obtaining short-acting opioids to feed the addiction, avoid withdrawal, or to self-medicate. Until recently, a referral to substance abuse services was the main treatment offered to these patients in the ED; however, with opioid use disorders, this intervention has limited benefit while a patient experiences withdrawal or craving. Now, buprenorphine, a partial opioid agonist, is available to treat opioid dependence. Buprenorphine decreases the withdrawal and cravings for opioids, is available from outpatient physicians, and, in contrast to methadone, has ceiling physiological respiratory effects [22]. A recent study has shown that ED initiation of buprenorphine treatment has improved patient engagement in community treatment and decreased self-reported abuse of opioids [22]. This study, however, included physicians who were educated in buprenorphine administration and had referral sources that were outside standard ED care. Patients that received this treatment used less inpatient time, which in turn can reduce ED boarding. Nevertheless, such medications are still rarely administered in general emergency rooms despite their rising presence in crisis and inpatient units.

Another issue for ED physicians and staff is the involuntary hospitalization of a psychiatric patient. Different states confer various degrees of authority and responsibility on the ED staff for forced treatment. Thus, physicians have to be educated on their roles which vary for each state. Fortunately, these statutes are usually well documented in multiple sources, such as the Treatment Advocacy Center [23].

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## 2.7 Resources Needed

Specific emergency mental health units with qualified staff can reduce the length of stays, security man-hours, and restraint episodes in the hospital [20]. When these units are not available, professional consultations, either face-to-face or telemedicine, are used, especially when after-hours presence is required. Furthermore, a range of medications in both the oral and injectable form are needed to decrease patient agitation or anxiety and to reduce violence. Emergency departments require increasing resources for staff and medications to stabilize, treat, and discharge individuals into the community with a decrease in inpatient care, but further studies are needed to evaluate the availability of consultation services. One state decreased the number of emergency liaison psychiatrists despite increasing patient numbers and universal healthcare coverage [24].

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## 2.8 Consideration of Coordination of Care

Psychiatric care is increasingly based on a treatment team model that requires continuing collaboration between staff members. The ED can be a revolving door for psychiatric patients due to general noncompliance or a lack of outpatient resources. Usually, the staff is aware of the problem but lacks the knowledge and resources to address cases on an individual basis. Consequently, increasing numbers of EDs

have dedicated case managers that can coordinate with either inpatient, outpatient, or crisis services to help patients transition between care settings and navigate services [25, 26]. Still, even with specifically designated discharge programs, due to illness denial and a lack of insight in some individuals with mental illness, a high number of patients become nonadherent to their programs, which ultimately results in readmission. In fact, once linked with a psychiatric provider and aftercare, adolescents with psychiatric conditions were actually shown to have higher rates of readmission [27]. The reason for this paradox ranges from the nature of having an illness to brief length of stays with premature discharge, whereby access to the mental health professional forced the recognition of symptoms requiring hospitalization at earlier stages than for those without mental healthcare access in their emergency department or communities.

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## **2.9 Interaction with Probate Courts and Criminal Justice System**

Multiple studies have noted that deinstitutionalization is associated with an increase in the numbers of patients in the criminal justice system. Up to 61% of US adult prisoners have a mental health diagnosis, while 15–24% have a severe mental illness [27–29]. The suicide rates in prison are much higher than those of the general population, and close to 20% of detained adolescents had a prior suicide attempt [28]. Yet, a large number of detention centers do not have in-house psychiatrists and require emergency room personnel to evaluate and treat their patients. Incarcerated individuals, especially children, have higher psychiatric admission rates than their peers and longer length of stays. Still, there are few beds dedicated to these individuals leading to delays in care as medications are rarely initiated while an individual is awaiting admission.

The emergency department is also the first place of contact for many vulnerable individuals, including the elderly, children, and survivors of sexual assault and other violence. These individuals are at risk for physical abuse, sexual abuse, trafficking, financial abuse, and neglect. Most states have statutes that designate healthcare personnel as mandated reporters for individuals that cannot report or fend for themselves. Victims and survivors of these crimes not only require reporting and protection but also mental health treatment and integration into community and legal systems [30]. It is this latter requirement that is limited in emergency rooms without dedicated units and staff, as emergency care is only the first step in the recovery for these patients.

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## **2.10 Security Needed**

The ED staff is especially prone to workplace violence. The environment is overcrowded and has high traffic, elevated noise levels, patients in pain, and families in distress. The nursing staff is most exposed to this aggression, and some have come

to consider it an occupational hazard. Yet studies and research have shown that higher quality care can be delivered if the healthcare worker is confident in the safety of their environment. Previous theories and plans focused on the aggressor and interventions to decrease violence; however, there are an increasing number of publications and bodies of research that focus on healthcare staff, teaching them to evaluate body language and warning signs of violence, enabling them to adjust their mannerisms and outlook to de-escalate the situation [14, 31]. Still, despite focus on de-escalation, trained and uniformed security officers are frequently needed for the safety of all parties involved [16].

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## 2.11 Special Considerations

There are additional considerations for specific patient populations, including patients with suicidal ideation, neurodevelopmental disorders, and neurocognitive disorders. Current approaches to suicidal patients, with an emphasis on risk assessment and safety, do not focus on what the patient is asking for, namely, assistance and support [32]. A new view examines patient needs instead of suicide risk. Although this is more ideal and therapeutic than the current strategy, practical methods and liability limits its use since it requires a longer duration of patient engagement than most emergency departments can provide. Having noted that, crisis units frequently function as psychiatric observation centers and can engage the patient in such a manner and possibly safely discharge the patient to a community provider, allowing for long-term care.

Acute violence management and de-escalation has limited success in children, adolescents, and adults with autism spectrum and other neurodevelopmental disorders. Patients with these conditions often cannot communicate their needs, and are hypersensitive to environmental stimulation and changes, a common issue in emergency rooms [33].

These patients do not usually respond to strategies that are designed for individuals without communication deficits. One strategy designed to address this patient population is to provide “autism-friendly” emergency rooms. This strategy involves extensive training of staff on the condition and its comorbidities, modifying environments (e.g., specific rooms with minimal noise, lighting, and staff changes) and minimizing the different materials used to avoid hypersensitivities [34]. Still, the number of inpatient psychiatric beds dedicated to developmentally disabled individuals is considerably fewer than those dedicated to the general population; therefore, if admission is necessary, these patients tend to have considerably longer wait times and length of stays [34].

Patients with neurocognitive disorders also present a challenge to emergency rooms. These individuals access the ED frequently for pain, confusion, altered mental status, aggression, paranoia, or exacerbation of chronic illness. Their care in the emergency department is difficult as they are poor historians, are easily overwhelmed, and often become uncooperative. These patients require significant staff attention, as they can require constant monitoring to avoid unwanted outcomes [35].

An intensive evaluation for delirium is also warranted, as well as environmental safety modifications to reduce the risk of wandering and falls. This level of support is frequently limited in emergency rooms without dedicated psychiatric services due to shortages in staff, time, and space.

With the shrinking amount of available inpatient beds, psychiatric boarding time in the emergency room is now a common occurrence. Psychiatric patients remain in the ED far longer than other medical patients do. The original guidelines of minimal laboratory testing are based on admission requirements of medical clearance, but inpatient resources are dwindling to a point that multiple states are only showing 10 inpatient beds per 100,000 people instead of the 50 that healthcare experts recommend [16]. Hence, emergency rooms are now often the site of care for initial psychiatric treatment and the extent of medical evaluations is variable. Psychiatric medications, especially atypical antipsychotics, have varying effects on lipids, thyroid, hepatic, renal, and cardiac systems. They require baseline values and regular monitoring. For this reason, extensive laboratory and medical workups are completed on admission to the unit. Emergency departments with dedicated psychiatric units and staff are able to complete the required testing and start treatments while the patient is awaiting a bed, but the majority of emergency rooms without dedicated psychiatric staff will not do so, which results in a delay of care.

The emergency room is also a resource for patients with non-emergent conditions [36]. The concerns of these patients range from medication refills to noncrisis addictions to depression without suicidal ideation. Several states, such as Texas, provide for psychiatric urgent care (crisis stabilization units) to treat these patients and possibly decrease emergency room admissions [36]. These clinics are an intermediate level of care between inpatient and outpatient centers. According to the American Psychiatric Association (APA), these units can often provide continued stabilization and link patients to appropriate care in the community [36]. Coordination with these services can ultimately prove vital to increase the efficiency of emergent psychiatric treatment.

Finally, resentment, transference, countertransference, and poor triage also limit the effectiveness of emergency room treatment [37, 38]. The term “frequent flyer” is used to refer to psychiatric patients that repeatedly present to the emergency room, whether for narcotic addiction, psychosis from chronic noncompliance, self-harm, or homelessness. The underlying reasons for such presentation are often a lack of outpatient care or housing, and the emergency room becomes the final common pathway out of necessity. Furthermore, psychiatric patients are frequently primed toward feeling humiliation, especially when they are forced into compulsory treatment [37, 38]. The feeling of humiliation is itself associated with increased risk of violence, longer length of stays, poor compliance, and frequent rehospitalization. Fortunately, healthcare training now also focuses on empathy, privacy, and autonomy, which are key factors in decreasing the distress these patients experience.



## 2.12 Summary

Today's emergency department is becoming the first line of contact for both emergency and nonemergency psychiatric patients during a time that available inpatient treatment is significantly decreasing. As a result, ED staff is frequently tasked with evaluating, treating, stabilizing, and dispositioning these individuals; however, the limitations of the traditional emergency room often hinder the care that these patients receive. The creation of a dedicated emergency psychiatric unit has helped to circumvent these limitations and has the potential to improve the emergency care of psychiatric patients.

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# Psychiatric Consultation to the Emergency Department and Co-Management Model

# 3

Karen M. Lommel, Joshua Richter, and Benjamin Griffeth

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## Abstract

There is an escalating issue of high volumes of psychiatric patients presenting to emergency departments. Therefore, many hospital systems have opted to employ in-house psychiatrists to evaluate and help manage these patients. Staffing of

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emergency psychiatrists can be challenging due to the shortage of psychiatrists and the nonstandard work hour requirements in the emergency department (ED). There are many unique challenges when treating these patients, including the difficulty of providing care in the emergency medicine environment and the relatively higher cost of providing psychiatric services in the ED. Personnel requirements in this model include emergency medicine providers, security officers, nurses, social workers, and psychiatric providers, all of whom require adequate training in the treatment of psychiatric disorders in the emergency setting. This type of training is not often addressed in traditional educational models. Safety is a particular concern and patients may receive sedating antipsychotics or other medications either during or before their ED stay. Patients in the ED may become violent, and hospital systems must be mindful to not normalize workplace violence for emergency healthcare workers. While not universally required, training programs exist for psychiatrists and Advanced Practice Providers (APP) who specialize in emergency psychiatry, though at this time none of these are Accreditation Council for Graduate Medical Education (ACGME) approved. This chapter addresses the co-management model of emergent psychiatric care in the emergency department.

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### 3.1 Introduction

Identification and treatment of psychiatric emergencies are essential skills to master in the practice of emergency medicine, especially with the shortage of mental health providers to assist on the frontlines when patients present to the emergency department (ED) in crisis. The role of providing psychiatric consultation in the ED has become increasingly important as acute inpatient psychiatric facilities are challenged with increased financial and regulatory burdens, nursing shortages, and fewer available beds. As a result, more EDs across the nation are serving as key entry points to the mental health system while, at the same time, accommodating total increased annual visits for primary medical *and* mental health complaints. It is important to note that the rate of increase in mental health-related visits has outpaced the rate of overall ED visits in recent years [1].

The prevalence of obesity, diabetes, and heart disease continues to increase across the US and other countries [2]; however, psychiatric disorders are projected to increase and rank second in the United States with respect to years of potential life lost (YPLL) [3]. The ED will be particularly impacted, given the previously stated increase in ED visits for psychiatric complaints. According to the 2010 Agency for Healthcare Research and Quality Report, one out of every eight ED visits in the USA involves a mental disorder, a substance use disorder, or both. Mental health and substance use disorders account for over ten million emergency department visits per year [4].

While there are a variety of different consultation staffing models utilized in emergency departments across the country, the model chosen is often determined by

the volume of the ED as measured in number of annual visits and by the available resources. It has become more common for low-volume (usually rural) emergency departments to utilize a trained charge nurse, social worker, or embedded community mental health center employee to help assess the patient, but who is primarily involved with disposition. In many areas there has been a growth of for-profit telepsychiatry companies offering consultation to emergency departments. The use of telepsychiatry has both a positive and negative impact on ED flow depending upon the model and the familiarity of the consultant with state involuntary hold laws and awareness of local resources to facilitate discharge.

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## 3.2 Liabilities and Capabilities of the System

One of the primary challenges in the psychiatric consultation model within the emergency department continues to revolve around the staffing of the psychiatrist position. It is easier to find a psychiatrist who is willing to provide consultative services from 8 a.m. to 5 p.m. than it is to find enough psychiatrists to provide 24/7 coverage. Unfortunately, with the national and international dearth of psychiatrists, many emergency departments still lack services. Psychiatric services can be provided by contracted or hospital-employed psychiatrists. In both scenarios, the hospital needs to subsidize the physician's compensation because revenue from billing is typically inadequate. With contracted work, the psychiatrist can bill independently. Employing a psychiatrist to provide consultative services in the emergency department may also allow the same psychiatrist to provide other services such as consultation-liaison services. This situation brings a tremendous amount of support and improvement of care to psychiatric patients as compared to no services, yet lacks the significant benefits of timeliness of care and improved patient safety seen in the full-time services of a psychiatric emergency center [5].

Overcrowded EDs are less than optimal places to address the special needs of mental health patients. Many patients have a history of trauma that can be exacerbated by their current crisis and by their placement in a busy emergency room with medically ill patients. Intensive and emergent care required for a very ill medical patient can result in decreased surveillance of the psychiatric patient who may become increasingly agitated and ready to act in a detrimental manner. Many hospitals employ contracted security services to help address this issue. Patients in psychiatric crisis consume not only medical staff time but also security resources in these situations [6]. Furthermore, prehospital crew members frequently express frustration with the time-consuming tasks involved in caring for a patient in the midst of a psychiatric crisis. Across the nation "high-volume utilizers" of the ED increasingly burden prehospital and emergency department providers, and this can negatively impact the care of patients [7, 8].

The projected increase in utilization of the ED also carries an associated cost. One of the most significant increases in ED visits is patients presenting with suicidal ideation, with or without suicidal gesture or attempt. The number of patients presenting with suicidal ideation has doubled between 2006 and 2013 with a

subsequent increase in cost of care. The majority of ED visits related to suicidal ideation resulted in admission to a psychiatric hospital [9]. The Joint Commission began focusing on care of the suicidal patient in the healthcare setting in 2016 and published a Sentinel Alert in March 2016. The alert provided screening, risk assessment, treatment, and follow-up care recommendations for at-risk individuals. The Sentinel Alert also suggested actions for educating all staff about suicide risk, keeping healthcare environments safe for individuals at risk for suicide [10]. The Columbia-Suicide Severity Rating Scale (C-SSRS) has become a standardized screening instrument used across the country for screening and risk stratification of patients presenting to healthcare facilities [11].

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### 3.3 Limitations of the System

As with any system as complex as the modern emergency department, there are constraints and limitations that can be challenging in the care of psychiatric patients. The ED has become the default place of first presentation for many ill patients, both with and without psychiatric complaints [12]. With deinstitutionalization and the widespread lack of community psychiatric resources, especially for those who are uninsured, wait times are longer and psychiatric services are more difficult to access. This has led to the ED being propelled into a more prominent role in the delivery of acute psychiatric care [13]. In general, the ED is designed to see patients of all levels of severity, from myocardial infarctions to minor lacerations to trauma to psychotic depression; however, this does not mean the ED is necessarily the ideal setting to treat acute psychiatric problems. When ED patients require psychiatric consultation, their length of stay tends to increase. During this period, psychiatrically ill but medically stable patients can end up inappropriately occupying a medical bed. In an ED with psychiatric consultation services, there can also be redundancy with regard to physician treatment. There may be little or no need for emergency medicine trained physicians to tend to these medically stable patients, as the majority of psychiatric patients will not require medical treatment during their ED stay [14]. Nevertheless, emergency medicine (EM) physicians should be careful not to become complacent with psychiatric patients as they may continue to require treatment and medical stabilization or may experience adverse reactions to medications administered.

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### 3.4 Personnel and Staffing Needed

There are several models of psychiatric consultation to the ED which depend upon the resources available. Personnel should include emergency medicine providers who have been trained in frontline management of the psychiatric patient. The clinician who has developed the best rapport with the patient should lead de-escalation communication with the patient. Therefore, nurse and physician leaders should work together to develop appropriate staffing with training on de-escalation techniques, proper use of restraints, and appropriate documentation.

One method to develop a consultation system would consist of three categories that include personnel, process and procedures, and environment of care. These recommendations echo the American College of Emergency Physicians Best Practice Recommendations for care of psychiatric patients in the ED [15].

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### 3.5 Patient and Staff Safety Concerns

Patients who present to the emergency department are often accompanied by emergency medical services (EMS) but more often, they are accompanied by law enforcement personnel, although significant variations occur by state. It has become more common for emergency medical services (EMS) and prehospital crews to utilize ketamine to address the severely agitated patient to ensure they remain safe during transport [16]; however, this can create problems upon arrival if the medication causes exacerbation of psychosis or has a complete lack of effect. As a result, the emergency physician (with or without psychiatric backup) could encounter an unpredictable situation in terms of how the patient may regain consciousness.

Other patient and safety concerns revolve around the proper assessment of the patient. For example, excited delirium or alcohol withdrawal could be misdiagnosed as psychosis or intentional criminal behavior, and a lack of treatment of the medical condition could be fatal [17].

Violence in the workplace is increasingly prevalent in the ED. More than half of emergency nurses reported verbal and/or physical violence over a 7-day period, and the vast majority of these incidents were perpetrated by patients [18]. Agitation and physical attacks are not uncommon in US emergency departments, and hundreds of thousands of patients present every year with agitation. Even more concerning, patients bring guns and knives to the ED on a daily basis [14]. Subsequently, there is increased focus on addressing violence against healthcare workers.

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### 3.6 Collaboration Needed

A psychiatrist who works in the ED setting needs to collaborate effectively with the health care team. Given the fact that a single psychiatrist cannot provide services 24-h a day, a team approach with multiple psychiatrists, social workers, trained psychiatric nurses, physician assistants, and nurse practitioners should cover the remaining shifts. Such individuals are typically employed by the ED. They provide consultation and assist with coordination of care with the emergency department personnel. That said, the best opportunities to improve patient care involve direct liaison with the emergency physician. There is also significant need to coordinate care with local mental health agencies, inpatient psychiatric facilities, and consultative services for those psychiatric patients admitted to the medical and surgical floors. The handoff from emergency psychiatric services to the inpatient team is essential for coordination of care.

### 3.7 Expertise Needed

At this time, there are no approved American College of Graduate Medical Education (ACGME) fellowships or subspecialty boards in emergency psychiatry; however, there are large hospital systems that have instituted non-ACGME fellowships for psychiatrists or emergency physicians. The usual fellowship duration is 1 year. There are also fellowship/residency opportunities for physician assistants (PAs) in emergency psychiatry, with the goal of providing a foundation for eligibility to sit for the Certificate of Added Qualifications (CAQ) exam in psychiatry. These programs may become more popular given the unique aspects of this environment which require specific clinical and leadership skills.

The psychiatrist's interactions with the emergency medicine physicians and advanced practice providers (e.g., nurse practitioners and PAs) are essential to function efficiently. It is important to note that the subspecialty of consultation-liaison psychiatry (also referred to as psychosomatic medicine) covers the training and skill set for the psychiatrist in the emergency department, but is not as focused on the ED as the previously mentioned emergency psychiatry fellowships. Given the nationwide shortage of fellowship-trained psychiatrists, the general psychiatrist with an interest in the interplay between medicine and psychiatry may be the frontline provider performing consultation to the emergency department. In large academic centers, the residents often cover the ED as part of their consultation-liaison rotation or night float call. Many hospitals have also opted to employ master's level social workers to perform initial consultations with backup by the psychiatrist. A skilled psychiatric nurse may also fill this role with backup from the psychiatrist on call. Furthermore, with the paucity of child psychiatrists, the adult psychiatrist may be evaluating the child in the ED, but this situation also has limitations.

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### 3.8 Considerations of Coordination of Care

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law in the United States that mandates emergency departments treat and stabilize emergent medical conditions regardless of the patient's ability to pay [19]. This legislation is an important consideration, especially for emergency departments with attached psychiatric hospitals, as patients may not be transferred unless the accepting hospital has the capacity and capability to care for the patient [20]. Refer to Chap. 1 for additional information on EMTALA and the care of the psychiatric patient.

As with any service providing care to patients in the ED, handoffs are critical. The consultant psychiatrist needs to concisely convey information to psychiatric colleagues and liaise with the EM. In smaller EDs where it is not possible to provide 24-h psychiatric coverage, written handoffs assist when transitioning care from one psychiatrist to another who may not arrive until the next day. Of course, in-person handoffs are always preferred when possible.



Ideally, multidisciplinary meetings involving the EM physician, consultant psychiatrist, any psychiatric advanced practice providers, nurses, and social workers from both the psychiatric team and the emergency department would be held at each shift change. This can be an efficient way to transition care and ensure consistency of information; differing schedules and fluctuating patient loads often presents a barrier to this ideal situation.

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### 3.9 Interactions with Probate Courts and the Criminal Justice System

A psychiatric consultant to the ED typically has regular interactions with the legal and criminal justice system. Sometimes, law enforcement is simply transporting the patient to the ED as the most efficient means of completing a psychiatric evaluation. According to Lu [21], up to one quarter of elderly psychiatric patients were transported to the hospital by law enforcement. In many states, police have the ability to place patients on involuntary civil commitment (ICC) and transport them for evaluation [22].

All states have legal provisions for providing ICC, but these rules vary by state. Both the psychiatric consultant and emergency medicine physicians should be familiar with the local regulations governing involuntary hospitalization. ICC often requires an evaluation by a psychiatrist. Access to a psychiatric consultant in the ED can decrease patient wait times for psychiatric evaluation and allow for more rapid determination of the treatment plan. Mandated outpatient substance abuse and mental health treatment is also available in some states. The psychiatrist can determine the appropriateness of these forms of outpatient commitment [23].

An unfortunate, but vital, function of any provider is the mandated reporting of child and elder abuse and threats of violence against others. Rules on mandated reporting vary by state, but in general, all healthcare workers are mandated reporters. Because of the nature of personal information elicited in psychiatric interviews, the psychiatrist may uncover abuse, neglect, or homicidal thoughts not easily obtained otherwise in the fast-paced ED [24, 25].

Treatment of persons incarcerated or detained is not uncommon. Almost 20% of detainees have serious mental illness and suicide is a leading cause of death in prisons [26]. If appropriate psychiatric services are not immediately available, patients may present from jail or prison while still in custody. Alternatively, law enforcement may bring a patient who has just committed a crime to the ED and requires a medical screening exam prior to transport to jail. When dealing with inmates, it may be necessary to disclose safety threats to the proper authorities, including threats to instigate violence in jail, plans to escape prison, or otherwise put others at risk of harm while maintaining privacy for other health information. Malingering should also be considered, particularly when working with the incarcerated population who may prefer inpatient psychiatric hospitalization to jail or prison [26, 27].

### 3.10 Security Needed

The presence of security in most emergency departments varies by location, size, and the role of other agencies. Some facilities are staffed primarily by security agencies without law enforcement authority, but when the need arises for law enforcement intervention, the emergency department team will need to rely on the city or county law enforcement officers to arrive in a timely manner. Many hospitals are moving toward staffing with internal law enforcement officers who are able to transport patients on involuntary commitment to other facilities and also arrest patients who exhibit criminal behavior not directly related to mental illness in the hospital setting. In such cases, the consulting psychiatrist is frequently asked to make this determination and assist with disposition.

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### 3.11 Special Considerations

It is necessary to include elements that are not suitable to the treatment of psychiatric patients in the physical environment of an ED. Medical equipment can be used by the suicidal patient to harm themselves or by the psychotic or intoxicated patient to harm others. Incidents range from strangulation with intravenous (IV) lines to assaulting staff with oxygen canisters to the alcoholic patient who drinks hand sanitizer from the wall-mounted dispensers [28]. Modification to make the ED environment safer can lead to decreased efficiency. Removal of medical equipment for safety reasons makes it impossible for these beds to be readily flexible for acutely medically ill patients. Some emergency departments utilize the internal garage door mechanism to cover medical equipment, computers, and medical gases for rapid conversion between psychiatric and medical room. In 2016, the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) advised increased awareness of caring for the suicidal patient and ligature risks in healthcare settings. The Joint Commission (TJC) subsequently issued the November 2017 Perspectives Preview: Special Report: Suicide Prevention in Health Care Settings [28]. In the report, there is significant emphasis placed on risk assessment and ligature risk mitigation through the removal of cords, ligature points, and placement of 1:1 sitters within the room for suicidal patients in emergency departments and inpatient medical units.

In EDs, there is often a lack of specialized psychiatric training for nursing support and other staff members who may not be as comfortable as specialized psychiatric staff working with patients with serious mental illness. In particular, it is important for security and law enforcement staff stationed in the ED to be trained to react appropriately when a patient experiencing a psychiatric crisis makes a threatening statement or becomes violent.

### 3.12 Summary

In summary, a multidisciplinary team is crucial for the appropriate care of the mental health patient in the emergency department. The size of the emergency department (i.e., volume or number of visits per year) often dictates the type of resources available for all specialties, especially psychiatry. Emergency physicians in smaller community hospitals are often faced with providing the majority of frontline psychiatric care but as the hospital system or size increases, the type of resources often increases with the volume. Large tertiary care centers will often have psychiatry residency programs with residents staffing the ED. Psychiatric social workers or psychiatric trained nurses may also be designated as assessment and referral services to assist with placement after the emergency medicine provider has determined the patient requires admission. There are more emergency departments embedding full-time emergency psychiatrists in a co-management model to improve the care of psychiatric patients presenting to the ED in crisis.

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# Adjacent Psychiatric Emergency Services to the Main Emergency Room

4

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## Abstract

A psychiatric emergency service (PES) is an autonomous or semiautonomous clinical service that collaborates with a general emergency department to deliver behavioral health services to patients experiencing psychiatric crises. Workflow, care teams, and clinical space may be shared between the PES and main emergency department with the goal of providing patients with acute psychiatric presentations specialized, coordinated care. While this care model can offer patients streamlined mental health services, it also requires strong working relationships

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with the main emergency department care team to optimize patient safety and care. This chapter discusses the limitations, advantages, and other aspects of this model.

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## 4.1 Introduction

There is a substantial and growing need for emergency psychiatry services. This need spans the patient care spectrum, including pediatric [1], adult [2], and geriatric populations [3]. However, despite frequently seeking emergency care, individuals with acute psychiatric concerns often encounter emergency rooms that are less than optimally prepared to attend to their treatment needs. Psychiatric emergency services (PES) can improve upon this by offering environments, workflows, and approaches that are tailored to this patient population.

A PES refers to an autonomous or semiautonomous clinical service that is closely connected to a larger medical emergency department (ED). While PES models exist throughout the United States and globally, standardized guidelines with recommendations on the optimal PES design and delivery of day-to-day care are lacking. Only limited outcome data are available to inform the development of guidelines for a PES. In this setting, the diversity of PES practices is evident in the literature. For instance, the term PES may refer to a dedicated psychiatric wing within the larger emergency department with overlapping staff and oversight from a general emergency room physician. However, the term may also refer to a separate psychiatric service near a main emergency department with its own locked unit, specialty trained staff, and separate workflow and procedures. In this situation, the main emergency department (ED) team may or may not participate in a patient's care prior to the psychiatric team's involvement. These two scenarios represent different ends of the PES spectrum, and many programs exist somewhere in between. This variation should be considered when reviewing this chapter's information and, where possible, will be acknowledged.

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## 4.2 Liabilities and Capabilities of the System

Perhaps a PES's most attractive feature is the focus on optimizing psychiatric emergency care and the psychiatric patient experience. Time, clinical space, and personnel expertise are often in high demand within a general emergency room. With their unique features and requirements, behavioral health emergencies can strain these limited resources or be an imperfect fit with what is available. Having a specialized service for patients with these needs can offer better care while enabling the main emergency room to operate unencumbered.

One useful customization is the workflow and expected timeline within a PES environment. On average, patients with psychiatric presentations have longer length

of stays than patients with nonpsychiatric presentations [4, 5]. Length of stay considerations can be built into a PES workflow, leading to less time pressure for disposition decisions, a typical problem for an emergency department. Enabling a patient to remain in a PES for short-term stabilization can enable agitated patients to de-escalate, give intoxicated patients a chance to metabolize their substances, and provide psychotic patients the opportunity to receive antipsychotic medication. This opportunity for stabilization can help avoid unnecessary hospitalizations [6]. The average length of stay for patients with psychiatric presentations can also be shortened in a PES environment by creating a better match between the available services and the patient's needs [7]. Patients with psychiatric emergencies frequently require specialized resources and discharge options, and general ED staff may not have the time or specialized knowledge to follow-up on psychiatric treatment options when patients with other acute medical conditions, like strokes or traumas, are also requiring attention.

Along these same lines, a PES can support the training and development of staff with a psychiatric focus, maintain the physical proximity and shared systems with a general ED, and allow for continued collaboration with the general ED team. This balance of psychiatric specialization and general medical knowledge can be especially beneficial when treating patients with concurrent acute psychiatric and other medical issues, a likely scenario with the aging population.

A physical environment that is more conducive to patients with acute psychiatric needs is also an asset of PES units. Emergency departments are often noisy, brightly lit, and have little privacy. These features are often countertherapeutic for patients with behavioral health concerns and can lead to increased agitation, a poorer patient experience, or impaired recovery [8].

In addition to the above benefits, a PES has the capability of providing services while minimizing unnecessary resources or care. By diverting unnecessary inpatient hospitalizations, the PES not only offers patients appropriate, less restrictive care, but the unit also saves the financial cost of a hospitalization. A PES can be costly to run, however, when considering construction or remodeling, staffing, and other operating costs. If there will be 3000 or more patient contacts per year, a PES is typically thought to be a viable option despite the potential costs [9].

Overall, a PES can provide specialized, streamlined care in an efficient manner. There is a need for more outcome research in this field, but thus far the PES model has demonstrated high patient satisfaction and positive response [10]. Decreased elopements, increased completion of the mental status exam, and decreased amounts of medication administered have all been demonstrated in PES environments [7]. As previously mentioned, a PES can also decrease the length of stay within this patient population in the ED while simultaneously helping to reduce unnecessary hospitalizations when quick stabilization is sufficient. All of this makes the PES model an appealing option for hospitals who manage a steady volume of patients with acute behavioral health or substance use concerns.

### 4.3 Limitations of the System

The PES model is not without its downsides. These drawbacks can be categorized as challenges associated with having a larger care team, patients' feelings of stigma, and challenges with the physical environment.

In addition to benefits from having both medical and psychiatric providers participate in a patient's care, there is also the potential for confusion, redundancy, and delays. A PES requires careful coordination and communication between the general ED and psychiatric providers regarding everyone's role. Even with good communication, there is the potential for delays in care. For instance, an emergency physician may evaluate the patient but then opt to withhold any treatment until the psychiatric team completes its assessment. This is typically either because the ED physician would like the psychiatrist's expertise in treatment decisions or because he or she feels it would be beneficial for the psychiatrist to assess the patient's symptoms in an unmedicated state. In some PES, all presenting patients are seen and "medically cleared" by an emergency physician prior to a psychiatric provider's involvement. For patients with only a behavioral health issue, seeing a general emergency room clinician first may add to the length of stay and add redundancy in the evaluation with no additional value to the treatment. Telling one's story leading up to his or her presentation multiple times can also impair care as the patient may feel frustrated and disengaged.

Beyond coordination concerns, patients with acute behavioral health needs may feel stigmatized when they are treated in a separate unit from patients with nonbehavioral health presentations. Patients referred to the PES receive care from a team focusing on their psychiatric presentation, which at times may be different than the patient's formulation of their main concern. The PES may also be locked, in contrast to most general EDs. In an era of integrated care, separating patients with physical and mental health presentations could relay an "unintegrated" message.

A final limitation of PES care is challenges with the physical space. Despite being focused on the care needs of those with behavioral emergencies, a PES is still often within or close to a busy ED whose milieu may be difficult to completely negate. An area where all patients have acute behavioral health and substance use concerns can create an intense and, at times, overwhelming situation. Poor patient experiences or safety incidents can occur, especially when agitated and intoxicated adults, vulnerable children, and older adults with neurocognitive concerns all share the same unit.

There are issues with patient overflow that need to be planned for as well. If there are few dedicated PES beds, the area may easily back up and lead to patients with behavioral health presentations being placed in other ED areas. If staff training and workflow efforts all presume that the PES will be where patients with psychiatric emergencies are addressed, then these patients in overflow situations may receive compromised care. The reverse situation may also occur, with the PES becoming an overflow area when the main ED area becomes too busy, a situation that can interfere with care for both psychiatric and nonpsychiatric patients.



As discussed above, a PES does have its limitations. Limitations, and capabilities for that matter, will vary depending on the specificities of each PES. These limitations can be mitigated with thoughtful planning and preparation, and some ways to optimize care will be discussed in the following sections.

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## 4.4 Personnel and Staffing Needed

Variations occur among PES staffing models. Some differences include the care team's professional background, the amount of specialized psychiatric training that staff has received, and whether staff work exclusively within the PES or if they have other concurrent responsibilities outside of the PES. Potential PES staff members include mental health or general medical technicians, social workers, resource coordinators, nurses, psychiatrists, mid-level providers (nurse practitioners or physician assistants), general emergency physicians, resident physicians, and others.

Some PES facilities, especially those with fewer beds, rely on a staffing arrangement where most, or all, of the staff members are simultaneously caring for patients in the general emergency room or inpatient floors. In this case, the psychiatric expertise may come from the hospital's psychiatric consultation-liaison service. In other PES, there is fully separate staff that exclusively serves patients within the PES. Within this spectrum, some programs have blended staffing where certain team members, such as the nursing staff, care only for PES patients, while other team members, such as the psychiatrists, have other concurrent responsibilities in other hospital areas.

Regardless of the care team's arrangement, specialized behavioral health training, both during the staff's initial pursuit of his or her professional degree and through continuing education, is often a worthwhile investment. PES staff is charged with caring for patients with acute psychiatric needs, which often requires a different knowledge and skills set than caring for patients with other acute medical needs. In addition, they must navigate and diffuse interactions among the PES patients, all of whom are ostensibly suffering from mental health crises. Staff with training that focuses on these situations can more competently and confidently carry out their responsibilities.

In addition to the PES team, there is often a general emergency room team, or at a minimum a primary clinician, who will assist with an initial medical assessment and "medical clearance" prior to the psychiatrist's involvement. This clinician may be responsible for ensuring that the patient's presentation is not primarily due to a medical issue such as a stroke or delirium, conditions that would be better attended to by an internist, neurologist, or emergency room physician. During this initial workup and triage, the ED clinician will generally perform an assessment and exam and order labs and imaging as needed. While there is debate on what constitutes "medical clearance" [11], PES programs often require that this is completed prior to becoming the patient's primary care team.

On the PES end of care, several key figures are needed to enable optimal care delivery, including nurses and medical or mental health technicians. These individuals are typically the first line to interact with the patient. Having nurses and technicians who feel comfortable working with patients experiencing psychiatric emergencies is critical, as these team members will need to quickly recognize subtle findings, decompensations, increasing agitation, and safety risks among patients.

A social worker also frequently plays a large role in the PES, as this individual assists the patient in having a smooth and successful transition to their next step in care. Disposition options for patients with behavioral health or substance use emergencies are typically different than for patients with other medical emergencies; a social worker or another resource coordinator who is familiar with these options is a huge asset to the care team. In addition to disposition assistance, some social workers will perform detailed mental health assessments either in lieu of, or in combination with, a psychiatric provider.

A core PES team also requires one or more clinicians to lead the diagnostic workup and treatment plan and to verify the patients' next steps in care. A psychiatrist may be the sole or supervising clinician with assistance from a resident physician or mid-level provider. In some programs, a psychiatric nurse practitioner or general ED physician serves as the main clinician, possibly with psychiatry consultation available via phone [10].

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## 4.5 Patient and Staff Safety Concerns

Patients evaluated in PES units typically include those who are there both voluntarily and involuntarily. This diversity creates the need for individualized interactions and treatment responses that can vary according to a patient's presenting concern. Patients with certain risk factors, such as substance intoxication or withdrawal and those who have a history of violence, are at higher risk for acute agitation and aggressive behaviors; these behaviors can place other patients or staff members at higher risk for harm if not identified and addressed in a timely manner [12]. Safety concerns include patient-to-staff harm, patient-to-patient harm, and patient self-harm, all of which can occur via direct physical contact or even with the aid of unattended hospital equipment. Harm may also occur in the form of unrecognized substance withdrawal, a missed primary medical etiology due to a patient's pronounced psychiatric symptoms, or due to a long wait time until evaluation. This last scenario may lead to escalation in agitation or attempts at elopement.

A PES is typically designed with a focus on decreasing the risk of patient self-harm, aggressive behaviors toward others, and elopement. These units should have readily accessible security personnel, as patients may quickly become agitated or aggressive toward others, particularly when intoxicated or undergoing an acute psychiatric crisis. In these situations, in addition to appropriate training, staff members need ready access to intramuscular antipsychotic and sedative medications to administer to patients. These units also are often designed as locked areas to prevent patient elopement, which can occur because of agitation, a desire to avoid

evaluation, fear of involuntary hospitalization, or acute paranoia. Constant patient observation should occur within a physical layout conducive to observation through modalities like video monitoring and observation windows.

The familiarity that the care team has with the PES and its patients also influences the unit's safety. Given the nature of emergency room shift work, staff members change shifts frequently. Without safeguards in place, miscommunication or loss of information may occur, resulting in inadequate care or underestimation of a patient's risk [13]. Patients may become confused due to frequent staff changes and may act out aggressively toward either unfamiliar staff or due to irritation from repeated questions. There can also be frequent staffing turnover within emergency rooms and with high patient flow [14], resulting in the presence of staff members who aren't adequately prepared to handle patients who are agitated or psychotic; this situation at its worst may result in injury to staff or patients.

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## 4.6 Collaboration Needed

The increasing prevalence of patients presenting to the emergency department with both lone and comorbid psychiatric illnesses requires careful coordination of care between the psychiatric and general medical emergency teams to best proceed with the patient's care. Frequently, patients in the chaotic emergency department environment need to be carefully triaged, evaluated, and medically stabilized or cleared prior to transfer to the PES unit where they can undergo a thorough psychiatric evaluation and treatment.

In some PES models, patients remain primarily under the care of the emergency physician throughout their stay, and the psychiatrist acts as a consultant. Without careful communication, this arrangement can result in a strained team relationship due to disagreements or misunderstandings related to the time necessary for the psychiatric consultant to evaluate, assess safety, diagnose, and give treatment recommendations. Overwhelmed emergency room staff may be tempted to expect the psychiatry team to do a "quick consultation." In the authors' experience, requests for consults to be completed in a waiting room or triage area have occurred, which may put both the staff members and patients at a safety risk while also compromising the patient's right to privacy. While it may be tempting to complete a consultation in this way, insisting that the emergency room staff finds a private area for the consultation will better support the patient and others' safety and privacy during the clinical interaction.

Patients who present to emergency departments with primary psychiatric concerns need some level of screening to rule out a medical emergency as a sole or contributory cause to their presentation. Previous studies looked for a screening tool to help quickly identify patients who can be safely referred for a psychiatric evaluation. A standard set of "medical clearance" lab tests for patients with psychiatric complaints is of low clinical utility [15]. Shah et al. proposed a screening tool of five questions (i.e., presence of stable vital signs, either a prior psychiatric history or age less than 30, fully oriented or a Folstein >23, no evidence of an acute medical

problem, and no visual hallucinations). In patients for whom all answers are “yes,” they may be considered medically stable enough for a behavioral health evaluation and require no further general medical workup [16]. While there is a need for a timely and efficient general medical evaluation in conjunction with a psychiatric workup, there are also instances where some patients’ initial evaluation may be too limited. Underlying medical emergencies may be overlooked in violent or uncooperative “psychiatric patients,” ED hyperutilizers, and individuals with chronic substance use. The psychiatric team needs to be able to discuss openly with the general ED care team any concerns or further evaluation requests that they have.

In some PES, patients with stable vital signs and no other medical comorbidities and who appear to have only a psychiatric component to their emergent situation may be directly triaged to the PES without the general emergency team’s involvement. Patients may also be triaged directly to a PES bed, but the psychiatrist will not become involved in care until after the “medical clearance.” In these situations, open communication and collaboration are even more of a necessity between the general ED and psychiatric specialists if during the evaluation there is concern for a medical component to the patient’s presentation.

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## 4.7 Expertise Needed

Knowledge of safety and security measures is paramount to a PES team. All staff members should undergo violence prevention training to lower the risk of patient harm to themselves, others, staff, or property. Security personnel and assisting staff need additional training on how to properly handle patients with agitation. This training includes de-escalation techniques and how to safely and humanely physically seclude and/or restrain a patient if anti-agitation medications or mechanical restraints are needed. Staff must have the knowledge and skill to lower the risk of harm while employing the least restrictive methods necessary.

For the entire PES team, proper knowledge and use of safety measures, such as panic alarms, restraints, and seclusion spaces, can help when addressing high-risk psychiatric situations for patients who are endorsing suicidal ideations, have a known history of impulsive behaviors or suicide attempts, or are in an intoxication or withdrawal state. The care team’s ability to recognize early symptoms of substance intoxication and withdrawal, as well as knowledge of the appropriate treatments for these conditions, will also enable the patient to receive the best possible care.

Many techniques can be applied to decrease the need for restrictive measures while also avoiding unnecessary harm to staff or other patients. Early recognition, de-escalation, relaxation techniques, clear and consistent limits, a decrease in stimulation, use of quiet rooms, and psychotropic treatment can all aid in reducing violence while adequately managing agitated patients. Furthermore, early recognition and monitoring for signs and symptoms of substance withdrawal is essential, especially when patients remain in the PES for some time before the appropriate next treatment step is possible. Finally, it is important to recognize at triage which

psychiatric patients are at risk for elopement, self-harm, or harm to others, as they may require immediate transfer to a locked part of the emergency department or necessitate a one-to-one sitter.

In addition to the knowledge and skills needed to manage patients' immediate safety, familiarity with other emergency psychiatry topics will also enable the PES team to provide patients with the best possible care. These core knowledge areas include:

- Accurate diagnosis and treatment of common emergency psychiatric conditions, including psychosis, mania, catatonia, and suicidality.
- Early recognition of alcohol and drug intoxication and withdrawal syndromes and appropriate treatment for these states.
- Identification of medical conditions that require further workup.
- Awareness of community resources and referral options, an area of knowledge especially essential for social workers and resource coordinators.

---

## 4.8 Resources Needed

A PES should be a therapeutic, safe, and comfortable physical environment for both patient and staff, as patients may be in the PES for many hours or even days. On average, patients in the ED awaiting an inpatient admission wait significantly longer (up to 3.2 times as long) compared to nonpsychiatric patients. A major factor in this statistic is the limited number of psychiatric inpatient beds nationwide [5]. These long stays can result in overcrowding, a lack of privacy, and a potentially harried environment for all patients in the area. A PES can mitigate these environmental stressors and help to minimize consequences of a crowded or chaotic environment, which can also help to avoid further destabilization or agitation in patients.

Treatment starts as soon as the patient enters the PES area, and the unit should be configured to optimize care. The living room model as trialed at UnityPoint Emergency Department in Rock Island, Illinois, aims to achieve this therapeutic environment [17]. This model was designed to provide a more natural and homelike setting, which may help de-escalate patients and provide a more healing surrounding, especially for patients who are in a psychiatric crisis. Features of this area include comfortable seating, reading items, television, natural wood materials, and other items that provide for a more calming environment [17]. Unit adjustments, such as soft lighting, soothing music, and therapeutic artwork decorations, can also help to maintain this therapeutic environment [2]. It is also important to consider safety in this model, with features described elsewhere in this chapter, such as unbreakable windows and broad video monitoring being helpful tools for early detection of any rising agitation.

Most data on the subject matter has been gained through anecdotal evidence or trial and error as there is limited data on an optimal design [18]. Along these lines, a longitudinal study is underway to ascertain a living room's impact on patient care [17].

## 4.9 Considerations of Coordination of Care

Out of all emergency psychiatry models, a PES requires perhaps the strongest coordination of care between psychiatric and general emergency department teams. This is due to the shared or closely connected environment, staff, and other resources. Ultimately the team needs to be able to effectively coordinate patient care with the available resources, often with the primary psychiatric clinician holding responsibility for ensuring that this occurs. To enable this coordination, many steps must happen, with accurate and timely communication facilitating this process. Typical contributions include:

- A primary psychiatric clinician (either a psychiatrist, mid-level provider, or appointed emergency physician) determining the treatment and disposition needs with the patient and coordinating the overall PES care.
- An emergency room clinician discussing the results of the overall workup and “medical clearance” process to the psychiatric team.
- A social worker obtaining collateral information about the patient and arranging for the patient’s admission to substance abuse treatment programs, short-stay crisis centers, psychiatric hospitals, community shelters, or outpatient psychiatric services.
- A pharmacist obtaining a list of past medications, current prescriptions, and noting any possible misuse of medications or duplicate prescriptions for controlled substances.
- The nursing team (nurses and technicians) helping to coordinate care and inform the treatment recommendations by providing other team members with their firsthand observations of a patient’s mental status and behaviors as the visit progresses.

To accomplish these tasks, good handoffs between treating providers and different shifts and an environment that is conducive to communication are essential. To this end, shared working spaces, dedicated phones which providers carry on their persons, electronic sign-out templates, and quick response provider hotlines can all be helpful. It is also important to have easily accessible security staff, interpreter services as needed, and an established relationship with community inpatient psychiatric facilities and residential crisis facilities. Finally, electronic access to, or accurate hard copies of, names and contact information is essential for in-house staff and outside facility providers who are involved in the treatment of psychiatric patients.

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## 4.10 Interactions with Probate Courts and Criminal Justice System

Interactions between PES units and the criminal justice system will vary based on state laws. When the police bring patients who are in a crisis to the emergency department, they typically do so because they determined that there is no better alternative in the community to provide adequate management of the crisis. In these

situations, the police may be able to provide collateral information, a description of the behavior leading up to the patient's detainment or relate previous encounters with the patient. This information can be useful in determining the most appropriate disposition for a patient and to support the evidence for an involuntary inpatient psychiatric commitment when appropriate.

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## 4.11 Security Needed

Typically, psychiatric services within the emergency department do not require dedicated full-time security personnel, but do benefit from quick, consistent availability of general emergency department or hospital security for emergency situations. Security should be easily accessible via phone, pager, or panic alarm system. A common reason for security assistance is to have support for acutely agitated patients, including those who are arriving at the hospital, those already admitted to the PES, and those in whom an imminent discharge may exacerbate agitation. Security officers can be helpful in these situations by offering "a show of support" or hands-on assistance if restraints are being applied or anti-agitation medication is being administered. Security officers may also oversee an initial search and storage of a patient's belongings to ensure that no potentially dangerous items are available.

As discussed previously, a PES also frequently offers a higher level of physical security in its physical design. In addition to being a locked unit, other security-enhancing features include patient rooms designed to minimize opportunities for harm with no removable objects, sharp edges, or ligature risks; safety-inspected locked bathrooms under nursing supervision; video monitoring; and panic alarms. With safety in mind, Grover and Lee describe a child and adolescent unit with door hinges that allow examination room doors to swing in and out to prevent patients from being able to block doors, televisions behind shatterproof glass, mobile monitoring equipment, the absence of sinks in rooms, bathrooms with automatic flushing toilets, hollow paper towel holders in walls, and alert buttons instead of pull cords in rooms [10]. It is essential that these designs should be consistent with The Joint Commission's standards for reducing ligature risks, as well, however [19].

Regarding patient attire, some ED facilities require changing into hospital gowns. Different gown colors in PES areas are sometimes used to discourage successful elopement, but this practice may also lead to feelings of stigmatization [14]. Patients and their belongings should be carefully examined to ensure that they do not have dangerous items, like weapons, or other countertherapeutic items, like recreational drugs.

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## 4.12 Summary

With its connectedness to a general ED and its focus on mental healthcare, a PES can offer the best of both worlds, offering patients both general medical and specialized psychiatric services. This availability of resources requires close coordination within and between care teams. The care coordination process is one of several



areas of diversity within PES programs, as PES also vary in the physical layout, workflows, care team composition, and in other domains. Amid these variations, PES enable hospitals with sufficient volume to deliver specialized care for the already large and growing population of patients with psychiatric and substance-related emergencies while also offering them support for comorbid or other acute medical needs.

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# Crisis Stabilization Services

5

Shawn E. McNeil

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## Abstract

Crisis stabilization services vary from a psychiatric emergency service that can observe and treat patients for 24–48 h to community crisis stabilization centers that are geared to the voluntary psychiatric patient who does not meet the criteria of grave disability or danger to self or others. All services provide a respite for patients and help to alleviate the burden of psychiatric patients in emergency departments. Services may include the ability to assess and treat acute psychiatric conditions, substance intoxication and detoxification, and psychiatric conditions in the context of substance use disorders. This chapter will focus on the voluntary community crisis stabilization center and discuss the limitations and capabilities of the system, personnel needs, and other aspects that must be considered.

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## 5.1 Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines crisis stabilization as a service which decreases the patient's severity of distress or their need for urgent care related to a mental illness or substance use. These services may include crisis stabilization units, community crisis centers, mobile crisis centers, and 24-h crisis lines [1]. These services provide relief to an individual in an emotional crisis and relieve the burden on overcrowded emergency rooms. They also bridge services for individuals with mental illness and substance abuse into outpatient follow-up [1].

Psychiatric crisis stabilization centers serve as an alternative to conventional psychiatric hospitalization. Some of these units will be psychiatric emergency services (PES), described elsewhere in this book, that allow for longer periods of observation. All patients receive medical clearance before admission to the center, and the distinguishing feature of these units is that the patients receive active treatment during their stay [2]. The longer observation period (24–48 h) allows the medications to take effect or the abused substance to be metabolized. Once stabilized, the patient may be discharged home with outpatient follow-up or inpatient substance abuse rehabilitation. If necessary, the remainder are admitted to an inpatient psychiatric facility. These units will be staffed with full-time medical staff, including physicians, nursing staff, and often social services. Patients will require medical stabilization before admitting to this unit. This type of crisis stabilization unit will take involuntary patients; those acutely suicidal, violent, or agitated; and those in the custody of forensic facilities [2]. Francis et al. found that the majority of patients who stay overnight in observation units are discharged to follow-up the following day; over three-fourths of the individuals involved in this study had a substance abuse diagnosis [3]. A later study by Breslow reached similar conclusions, except his study concluded that patients with personality disorder were more likely to have brief stays [4].

In contrast, community crisis stabilization units focus on nonviolent, voluntary patients. Individuals may enter and leave the facility as they desire and may remain longer than the 24–48 h limit for the crisis stabilization units mentioned above. Though physicians and mid-level providers (nurse practitioners and physician assistants) are on staff, they are not at the facility 24 h. These units may be funded by hospitals or community groups [2]. “The Living Room Model” is another term for this type of care [5].

SAMHSA defines mobile crisis units as teams that can enter into the community, often into homes, schools, etc., and provide a rapid response [1]. The teams assess the individual and work to resolve crises. A psychiatrist is present for the evaluation or available by phone. A specialized type of mobile crisis teams, the crisis intervention team, is discussed in Chap. 6.

The SAMHSA report [1] surveyed communities around the USA regarding the types of crisis stabilization services offered. Though the type of services available differed by the community, mention is made of the toll-free National Suicide

Prevention Lifeline that is available 24/7 to everyone and utilizes a single network for all crisis centers [1].

Community (voluntary) crisis stabilization centers will be the focus of the remainder of the chapter.

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## 5.2 Liabilities and Capabilities of This System

Though any individual may walk into a community crisis stabilization unit for care, these units are limited in the type of care they can provide. Some may have part-time psychiatric staff, and others may be strictly peer support (support provided by individuals with a history of mental illness). As a consequence, these facilities have limited abilities to treat or care for a violent, homicidal, or suicidal patient. Likewise, patients may leave at any time. This requires a certain amount of insight into their illness as well as a willingness to comply with treatment for the program to be successful. As involuntary medication may not be available, these facilities are not the best choice for individuals in acute substance withdrawal or psychotic agitation. Community crisis stabilization units also cannot care for individuals with severe and uncontrolled medical illness.

A review of the literature shows that for many patients, crisis residential treatment is sufficient to prevent an inpatient admission. Fenton et al. [6] randomized a group of chronically mentally ill individuals who were experiencing an exacerbation of their illness and willing to accept voluntary treatment to either an inpatient unit or to a community residential facility. Over 50% were successfully treated at their randomized treatment site; satisfaction and functioning 6 months later were equivalent. A more recent study demonstrated a decrease in scores on the Brief Psychiatric Rating Scale (BPRS) and Beck Depression Inventory Scale of individuals treated in a community crisis residential center [7].

These residential crisis centers may provide several additional benefits over traditional inpatient hospital admission. Studies show that individuals in crisis want a safe place to stay with supportive staff and medication if necessary [5]. Many community crisis stabilization units offer a homelike atmosphere; the Wellspring community crisis center in Louisville, Kentucky, is in a remodeled two-story home in the downtown area [7]. As the patients may leave the facility, some are able to attend school or find jobs. The community setting places the care of the patient in the community and strengthens ties for follow-up after discharge. This allows the patient time to discover ways to cope with an outpatient setting. Community crisis stabilization units are also potentially less stigmatizing than inpatient care [8, 9].

Peer support is a key component of the staff for community crisis stabilization units. Peer support personnel have a history of mental illness or substance abuse, may have been through the crisis treatment experience in the past, and have received training to support others on their way to recovery [10]. Landers [10] found that the presence of peer support increased crisis stabilization and decreased psychiatric hospitalization. In some areas, crisis stabilization units are “peer-operated respite,”

which are voluntary programs that are owned and operated by peers. Peer support is a Medicaid billable service in many states [10].

Community crisis stabilization units offer a safe, nonthreatening environment to individuals in crisis. They receive psychiatric and psychosocial assessment and treatment. Treatment modalities include observation, administration, and monitoring of psychiatric medication, individual and group therapy, crisis skills training, life skills training, and coping skills for use in future crisis episodes [11]. As an added benefit, community crisis residential services have a lower cost compared to inpatient hospitalization [12].

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### 5.3 Limitations of This System

Community crisis stabilization centers are designed for the specialized treatment of mental health conditions, and some patients will not qualify for admission based on medical comorbidities. Uncontrolled hypertension, diabetes mellitus, or epilepsy require stabilization before admission to the unit. Studies show that patients tend to underestimate substance use by 50% [13], and medical detoxification is often beyond the ability of the community crisis stabilization center.

The voluntary nature of community crisis stabilization units may mean that there is a flux in the number of individuals in residence at any point in time. Factors associated with increased utilization for psychiatric emergency care are younger age, homelessness, female gender, substance abuse, and schizophrenia [14–16]; this same patient population is likely to seek admission to community crisis stabilization units. They may present with complaints of suicidal ideation or other acute symptoms to obtain food or temporary shelter. Persecutory ideation may force seriously mentally ill individuals who arrive voluntarily away from much-needed care due to their distrust of the facility, staff, or other patients.

Community crisis stabilization centers are not hospitals; they likely lack intramuscular medications for agitation or controlled medications. Most will not have an in-house pharmacy and will need to have access to a nearby dispensary. While the facility may have a “calming room,” there is probably not a secure area for an agitated patient. As the unit is not locked and patients may leave and return, there is always the opportunity for individuals to bring in contraband drugs, alcohol, or other items.

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### 5.4 Personnel and Staffing Needed

A Task Force Report in 2002 by the American Psychiatric Association (APA) discussed the staffing needs of different types of community crisis stabilization facilities [9]. A facility that takes individuals directly from an emergency department (ED) will need sufficient staff to maintain 1:1 observation of those individuals for at least 24 h. In general, crisis stabilization facilities should include both professional and paraprofessional staff members. Professional staff should include a psychiatrist

who is on-call 24/7 and provides regular evaluations of the patients; psychologists; nursing staff, including mental health technicians; licensed social workers; peer support personnel; and, ideally, addiction medicine specialists. Housing specialists can help provide resources for those who are homeless. The use of telehealth technology may be an acceptable alternative to face-to-face evaluations by a psychiatrist, as long as local and institutional policies regarding the administration of telehealth services are followed.

Types of community crisis stabilization units will vary along with their staffing needs. The maximum capacity for *The Living Room* is six “guests.” Staff includes three peer counselors, one counselor, and one licensed nurse [5].

The University of Pittsburgh resolve Crisis Center accepts individuals over 14 years of age for the crisis residential service [17]. The 150 member staff includes psychiatrists, mid-level practitioners (advanced practice nurse practitioners or physician assistants), nursing staff, therapists, social workers, and peer support specialists. Many crisis centers, such as the resolve Crisis Center, also offer mobile crisis teams.

Mobile crisis teams involve therapists, social workers, and often nursing staff. The American Psychiatric Association (APA) Task Force recommends the availability of a psychiatrist on-call for these mobile teams [9].

---

## 5.5 Patient and Staff Safety Concerns

Acutely agitated or violent patients are not appropriate for direct admission to most community crisis stabilization units. However, any patient has the potential to become agitated or violent. This means that their safety, along with the safety of the other patients and staff, must be taken into consideration. Staff should have yearly training in managing behavioral emergencies in the least restrictive manner. This includes the use of de-escalation techniques to reduce the probability of a patient becoming violent. If the facility doesn’t have intramuscular medication available for crises, the use of loading doses of divalproex or antipsychotics (which are available in sublingual, liquid, or orally disintegrating tablets) can help calm an agitated individual [18, 19]; some experts recommend oral or inhaled formulations instead of intramuscular if the situation allows [20]. National and state guidelines must be followed for the use of seclusion, restraints, or involuntary medication. The facility must follow guidelines to ensure that it meets standards as determined by The Joint Commission for the prevention of suicide [21].

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## 5.6 Collaboration Needed

The management of a psychiatric crisis unit can be a multispecialty venture that involves the collaboration of many professionals. Psychiatrists should be involved in ongoing assessment and medication stabilization. Patients have more contact with nursing staff, counselors, and social workers; therefore, those individuals can

provide invaluable information to the psychiatrist which the patient may not appreciate. The staff also needs information from prior treatment providers, physicians, family, and friends and even the police. If at all possible, records should be obtained from primary care providers, hospitals, therapists, and previous treating psychiatrists.

Treatment plans are an important aspect of care within any behavioral health facility, including in community crisis stabilization units. All disciplines provide input for the plan; the patient is involved in the process. There is a continual assessment of the progress toward therapeutic goals.

An essential aspect of care is follow-up care. Before discharge, staff should ascertain that the patient has access to prescribed medication (in hand if possible), understands the side effects and directions for use, has an appointment for psychiatric follow-up within 1 week of discharge and a therapy appointment, and has a primary care referral and a substance abuse referral (if an essential element of the treatment).

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## 5.7 Expertise Needed

The staff who operate these crisis stabilization centers should be knowledgeable about the treatment of patients in crisis. This should incorporate training in the assessment and management of psychiatric emergencies, which may include agitated patients or those who need detoxification from substances. Staff should also be able to identify a patient whose needs are medical, as some psychiatric emergencies are the direct result of another medical illness or issue. Staff should be aware of trauma-informed approaches to interacting with patients as many of them may have a history of trauma or abuse.

As with any facility, job descriptions are important, as well as regular staff evaluations. Supervisory roles should be delineated. Employee records, just as patient records, should be kept in a secure, locked location [9].

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## 5.8 Resources Needed

An essential resource is the location of the community crisis stabilization center. As can be seen from *The Living Room* [5] and Wellspring [7], a homelike atmosphere can be helpful. Enough square footage and private rooms are necessary to have offices for staff, group rooms, and the secure rooms required for medication and record storage. Calming rooms and even seclusion rooms may be part of the facility. Patients should have private areas for sleep; adequate bathrooms with shower access are necessities [9].

Routine instruments, such as sphygmomanometers, thermometers, fingertip pulse oximeters, and stethoscopes should be available. Point-of-care tests, such as urine pregnancy tests for women of childbearing potential, blood glucose meters, and urine test strips, are additional necessities as some individuals will have medical

comorbidities. The facility directors should decide at the inception what additional medical equipment is necessary. As this is a community stabilization unit, patients with an unstable medical condition may need a referral to outside laboratories, medical offices, or hospitals for medical clearance evaluation or more extensive workups.

In contrast to the above, the 24–48 h crisis stabilization units often take patients directly from emergency departments; some may require a more extensive medical evaluation. Most encounters will involve the acquisition of vitals, lab work, and even imaging which will aid in ruling out any medical complications. With these resource needs in mind, these centers should have an onsite laboratory capable of running basic blood work and urine samples or have access to a central lab that can run the samples quickly and return the results in a reasonable amount of time. Equipment should also be available to conduct an electrocardiogram (EKG) and provide neuroimaging should the situation call for it. The reasonable availability of computed tomography (CT) and magnetic resonance imaging (MRI) technology will aid in conducting a complete patient workup.

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## **5.9 Considerations of Coordination of Care**

These facilities must be able to work cooperatively with other healthcare entities to provide optimal care for patients. Information from prior physicians, treatment providers, and hospitals will help with patient treatment. Coordination with follow-up agencies will provide ways for the patient to maintain improvements made during the unit stay. These agencies may include primary care providers, therapists, psychiatrists, addiction centers, and any other facility where the patient is referred to. As with all behavioral health facilities, staff must follow local and state regulations requiring mandatory reporting of child, adult, or elder abuse. Some jurisdictions also require the notification of child protection authorities of pregnant women who abuse substances. Likewise, staff should follow jurisdictional requirements regarding threats of harm to others made by a patient.

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## **5.10 Interactions with Probate Courts and Criminal Justice System**

Most community crisis stabilization centers will only take voluntary patients. Staff will need to contact the police, however, if a voluntary patient requires more intensive treatment in an inpatient facility and is unwilling to go. Crisis intervention teams which involve police (as described in Chap. 6) may bring in voluntary patients in need of a crisis stabilization unit. Law enforcement officers are often responsible for initially assessing situations involving psychiatric crisis and may bring a voluntary individual in for treatment.

In contrast, law enforcement may bring individuals in custody for evaluation and care to the PES units capable of a longer observation stay (24–48 h). Individuals in custody are not suitable for voluntary units.



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## 5.11 Security Needed

In psychiatric crisis centers, there may be several layers of security. All staff should understand the principles of de-escalating disruptive individuals, which can include patients in crisis. Certain staff members, typically the psychiatric technician, can have a more direct role with disruptive patients by providing one-to-one patient supervision, restraining a patient while administering medications, or placing a patient in physical restraints or seclusion. Depending on the location of the facility, security personnel may be advisable to monitor the premises. Locked areas are necessary for personnel, for patient record storage, and for medications.

Given the nature of the patient population, PES units with an extended observation period are more likely to have full-time security personnel, panic buttons, and even video monitoring.

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## 5.12 Summary

Psychiatric crisis stabilization services provide a useful service to the community as well as to patients with acute mental health needs and substance abuse disorders. PES units with extended stay capabilities of 24–48 h, community crisis stabilization centers, mobile cross teams, and crisis lines provide support for individuals suffering from an acute behavioral health problem. Community crisis stabilization centers, in particular, provide a haven for voluntary patients who are suffering from an acute mental health crisis. The availability of psychiatric assessment and treatment, staff observation and medication monitoring, group and individual therapies, and a supportive milieu are beneficial to many individuals. Furthermore, these facilities are cost-effective and relieve the burden of the rising numbers of individuals in psychiatric crisis in the emergency department. Community crisis centers provide benefit to the patients and the community as many individuals will only need a brief respite to recover and return to their baseline. More information about requirements for community crisis stabilization centers can be found in the APA Task Force Report Regarding Psychiatric Emergency and Crisis Services [9].

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## Abstract

A crisis intervention team (CIT) is a first-responder model of police-based intervention that collaborates with emergency department (ED) personnel and community treatment providers to optimize acute psychiatric treatment. Consistency with communication and collaboration among stakeholders is essential in yielding positive outcomes.

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## 6.1 Introduction

For nearly four decades, emergency psychiatric treatment has shifted from hospital emergency departments (EDs) to interdisciplinary mobile crisis teams evaluating patients in their homes and communities. This community-based treatment has reduced the problem of overcrowding and psychiatric boarding in EDs, as well as improved patient, law enforcement, and community satisfaction.

Although multiple models of crisis mobile teams exist, the Crisis Intervention Team (CIT) model is increasingly recognized as the gold standard and best practice for law enforcement [1, 2]. In this model, the CIT members (who) provide the emergent field response include a mental health professional and a police officer who has been trained on mental health-related topics that include crisis resolution skills, de-escalation, and access to community-based services. Behind the lines, police dispatchers who are trained in crisis intervention screen and identify calls that involve people in psychiatric crisis and then signal the CIT for a field response. CIT community support includes local EDs that enable law enforcement officers to utilize a centrally designated emergency drop-off site with a no-refusal policy, as well as local community mental health agencies, to ensure the patient is referred, as needed, for mental health treatment after they are discharged.

Approximately 3000 communities across the United States currently have active CIT programs, and similar models exist in Canada, Australia, and the United Kingdom [3, 4]; however, lack of standardization [5] has resulted in variability among CIT models so although there are many effective CIT programs, research findings on the effectiveness of the CIT have been limited.

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## 6.2 Liabilities and Capabilities of the System

The chaotic environment of the ED often exacerbates psychological distress and the patient's illness [6, 7]. CITs provide assessment and evaluation in the comfort of the patient's own home or community, which is much more therapeutic and naturally de-escalating. Furthermore, CITs reduce overcrowding in the ED and enhance both patient and officer safety.

The CIT model is particularly effective for those with severe psychiatric illness and a history of institutionalization or incarceration who find comfort and security in a hospital setting. These individuals typically lack social support, have poor social skills, are detached from the community [8, 9], and are unable to articulate their emotional needs. It is not uncommon for them to make statements or create situations that suggest the need for hospitalization. As a result of these histories, it is not out of the norm for both ED personnel and law enforcement to view them in a negative light, which results in these patients receiving inadequate care.

Because CITs are typically composed of a small number of individuals, both the patient and team members become familiar and comfortable with each other, leading to a reduced number of involuntary transports to the ED [10], as well as a reduction in the number of occurrences of violence and potential injury [3, 11].

Implementing the CIT model is instrumental in both the de-stigmatization of mental illness and the decriminalization of those suffering severe mental illnesses [5, 12].

Further, as psychiatric boarding becomes an increasing problem in EDs across the United States [13], evaluating patients in the community setting as opposed to the ED allows ample time for the patient to be thoroughly assessed and a comprehensive history gathered when determining the potential for imminent dangerousness. While some patients will require acute hospitalization, many do not and can be stabilized in the community if they are connected to the appropriate resources [14]. Besides the obvious benefit to the psychiatric patient, this also decreases wait times for ED patients in need of immediate care.

Issues that are mitigated by the use of CITs include: (a) a decreased wait time for law enforcement. CIT-trained officers are available at all times and they are specifically dedicated to mental health calls which enable patients to be evaluated within a reasonable timeframe; (b) the minimization of physical injuries sustained by the patient. CIT officer training in behavioral management also minimizes physical injuries [15]; (c) decreased stigma [16]; (d) increased treatment access [17]; and (e) adherence to the ethical standard of rendering the least intrusive intervention. Patients who are forced into a psychiatric emergency room against their will in situations that are later deemed unwarranted tend to develop a negative view of police officers and mistrust of the mental health profession overall.

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### 6.3 Limitations of the System

While there are many capabilities and advantages to using the CIT model, there is no true standardization where models are implemented. Lack of standardization, stigmatization, lack of communication or communication issues, and lack of consistency all have the potential to create issues once a CIT determines that a patient requires further assessment in the ED.

When a CIT recommends further assessment or inpatient admission, the patient is transported to the nearest ED. While inpatient psychiatric units require the patient to be “medically cleared” prior to being considered for admission, there is no consistent standard or definition of medical clearance. In addition to being medically cleared, the patient must also be diagnosed as being “imminently dangerous” (to themselves or others). To attain both medical clearance and a diagnosis appropriate for inpatient admission, the patient must undergo both psychiatric and physical examinations and wait for laboratory tests. This usually results in significant delays, especially if there is a boarding problem in the hospital, and increases patient frustration, thereby putting the patient at risk for worsening behavior.

At the same time, because of the stigmatization of psychiatric illness and the frustration of managing psychiatric patients that have repeated, numerous visits to the ED (“frequent fliers”), these patients are at risk for having legitimate medical complaints dismissed by medical and clinical staff in the ED. Although EDs try their best to ensure that this type of discrimination does not occur, the reality is that there are times that it does. This stigmatization can delay medical diagnoses, or fail

to rule them out, which can create a potentially dangerous situation, as some psychiatric symptoms can mimic or actually be caused by medical problems. This sort of relaxed approach can obviously lead to medical liability, but more importantly, it can lead to irreparable harm or the accidental death of a patient.

Efficient and ongoing communication and collaboration among ED staff is essential. Research suggests that partnership and collaboration are likely to improve patient follow-up with treatment after discharge, help to alleviate future behavioral health crises, and reduce recidivism rates to the ED [14]. While EDs have protocols in place for ensuring constant communication, the rapid pace in the ED throughout the day breeds many opportunities for error and lack of communication. Positive and accurate communication is especially important during shift change briefs or reports, when crucial information is passed on to the incoming clinical team who will be taking over care of the patient.

As previously noted in this chapter, the often stormy and intrusive environment of the ED is not conducive to patients in psychiatric crisis. ED staff members are not typically trained to effectively deal with or manage a patient who is experiencing acute psychiatric decompensation or who may be exhibiting the potential for aggressive behavior. The net result is often unwarranted restraint and medication, in addition to the increased risk of violence and injury to both patient and staff.

A lack of standardized and empirically validated risk assessment tools can also result in disagreements regarding the needs of the patient. Moreover, clinicians have varying levels of education, training, and experience, which makes their risk assessments vulnerable to subjectivity if not aided by the utilization of risk assessment tools. While there is mixed evidence regarding the accuracy of predictability in suicide and homicide prediction tools, using these tools may result in improved accuracy in both diagnosis and treatment [18].

Variability in the quality of CIT assessment and documentation can also be an issue. Accurate and objective descriptions of patient history, mental status, and dangerousness are critical, but the method of obtaining this information differs with each clinician. Involuntary hospitalization needs clear documentation of “imminent danger” and there may be disagreements between the CIT and the ED on whether or not that danger truly exists. Inaccurate evaluations can therefore result in a failure to meet standards of care. Moreover, evaluations that are vague or missing relevant clinical information necessary to determine patient disposition can delay the admission or discharge processes or even prevent insurance coverage for hospitalization.

Finally, the issue of burnout and vicarious trauma suffered by providers is an important and common problem that is largely disregarded. Both mental health and law enforcement professions involve chronic exposure to difficult patients and situations leading to stress, frustration, exhaustion, and cynicism [19]. If these issues are not addressed, over time, vicarious traumatization is likely for these professionals. Consequently, research indicates that burnout and vicarious trauma are associated with negative perceptions of patients, poor quality of care, job dissatisfaction, low retention rates, and absenteeism [20]. CITs and ED clinical staff would benefit from having a debriefing protocol that is routinely activated after difficult cases in the field or ED involving aggression or excessive conflict. Although interventions

for reducing the risk of burnout and vicarious trauma are limited, research suggests that there is a potential benefit from peer support groups, regular feedback on performance [21], and regular debriefing [22].

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## 6.4 Personnel, Staffing, and Expertise Needed

For CIT programs to operate effectively, core personnel required include CIT-trained officers and dispatchers, law enforcement and mental health coordinators, and advocacy and program coordinators. All facets of the CIT work together to ensure that potential psychiatric emergencies are identified; that patients are linked to mental health treatment; and that community agencies are coordinated with to support the end goal, which is always the least intrusive intervention appropriate for the patient.

During CIT training, officers receive 40 h of training on mental health-related topics that include crisis resolution skills, de-escalation, and access to community-based services. The format consists of in-class lectures, on-site visits to community mental health facilities, and interaction with individuals with mental illness. Trainers are comprised of mental health professionals, individuals with mental illness, police trainers, and patient and family advocates [23]. Dispatchers who are formally trained in crisis intervention are also an integral part of the team. Dispatchers are able to readily identify calls involving psychiatric crisis and determine whether to refer them for CIT services or transport them for a mental health evaluation. The community aspect of the CIT creates a fluid and streamlined process, enabling officers to utilize a centrally designated emergency drop-off site with a no refusal policy which allows them to return to their law enforcement duties promptly, and it enables timely treatment for individuals with psychiatric illness [24].

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## 6.5 Patient and Staff Safety Concerns

Utilizing trained community law enforcement personnel to respond to psychiatric emergencies ensures the safety of both healthcare professionals and the patient; therefore, it is imperative that all personnel involved in the field response work in tandem with law enforcement and follow the lead of the law enforcement officer to ensure the continued safety for all individuals involved [22].

While in the field, healthcare professionals should take general physical safety precautions that include: parking in an area with easy escape access, ensuring that all animals in the home are secured, obtaining a head count and the identifying information of all nonresponders at the scene, wearing attire that is conducive to limiting falls, standing rather than sitting during an evaluation, conducting an evaluation in an area outside the reach of objects that could be used as weapons, ensuring direct access to an exit, and standing at a distance of at least two-arm's lengths from the individual being evaluated.

It is crucial for all members of the CIT to be acutely aware of the behavioral indicators of escalation and to have working knowledge of the least restrictive methods of intervening with individuals exhibiting signs of escalation. The Department of Health's Restrictive Interventions Policy recommends ongoing education, training, and awareness on the use of alternative approaches to restrictive interventions, including conflict resolution skills training to ensure a safe and ethical practice [25]. To remain compliant with least restrictive intervention approaches, and to improve risk prediction and overall responder, patient, and treatment team safety, healthcare professionals and law enforcement officers should enroll in regular training and education programs on the early warning signs of behavioral escalation [26]. Behavioral indicators of escalation include a change in voice tone or pitch, inconsistent behavior, rigid or tense posture, pacing, threatening gestures or statements, invasion of personal space, and increased autonomic responses.

There is evidence that one of the precursors to aggressive behavior is the patient perception of poor communication; therefore, education and training in effective communication is also beneficial [27]. Effective de-escalation communication skills and tactics include assigning one individual to do the talking, utilizing open-ended questions to try to distract patients from angry thoughts, negotiating with the individual if a problem or conflict exists that has a solution, providing validation and empathy, and showing regret. Concomitant behavioral strategies include not overcrowding the patient, remaining at their eye level, and being present in the moment. In situations where the patient continues to escalate, enforceable, clear, and consistent limits must be set while remaining emotionally nonreactive, calm, and focused.

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## 6.6 Collaboration and Resources Needed

Relationships with outpatient community mental health agencies are an essential aspect of CIT programs. Collaboration efforts among community providers reinforce the philosophy of least-restrictive care by advocating for, and providing, community-based care rather than inpatient admission. For CIT programs to be effective, community mental health agencies must assist in the coordination of services and care both during and after a crisis.

During a CIT response, responders must have the ability to coordinate with all patient providers (both inpatient and outpatient) and gather collateral information from them whenever available. The CIT must also obtain collateral information from family and friends as an additional source of verification which will be used to assist in determining the level of patient risk and disposition recommendations. This is conducted in a manner consistent with maintaining confidentiality and providing effective care. Because some members of the CIT (e.g., police officers) are unlikely to have full knowledge of each patient's psychiatric and medical history or baseline, it is essential to coordinate with outpatient providers and family to determine imminent risk and appropriate treatment pathways.

In situations where patients are transported to the local ED for an evaluation and subsequently discharged back into the community, it is essential to establish a rapid bridge with outpatient appointments. Several lines of research support that rates of



recidivism to the ED are strongly predicted by aftercare [28]. Not only is the presence of aftercare important, but aftercare appointment timing is crucial; research suggests that the closer the follow-up appointment after a psychiatric crisis, the more likely that individual will appear for their appointment [29, 30].

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## 6.7 Considerations of Coordination of Care

Informed consent and the limits of confidentiality are significant challenges during psychiatric emergencies. It is the responsibility of the health professionals involved in treatment and coordination of care to maintain patient confidentiality, and careful attention should be given to ensuring this basic right.

During non-emergent interactions, healthcare-affiliated professionals may disclose a patient's private health information to significant others, outside providers, or other professionals after they have obtained the appropriate authorization for the release of this information [31]. Confidentiality assurance is not only critical for the effective recovery of the patient, but also for liability protection for the healthcare professionals involved [32]. During emergent situations, such as with CIT response, no prior authorization is required, and confidentiality does not apply as HIPAA (Health Insurance Portability and Accountability Act) specifically allows exception in cases of potential or actual imminent dangerousness.

On the other hand, the imminent danger exception also presents an obstacle as, in the United States (US), HIPAA only allows for exception as it pertains to healthcare-affiliated professionals. As currently written, laws on informed consent and confidentiality remain confusing and unclear as to how or if they apply to non-affiliated healthcare professionals, such as police officers, who are an integral part of CIT response. This makes it difficult to implement principles of coordination of care due to the various professional and legal standards and regulations to which healthcare providers are required to adhere [33, 34]. Although CIT maintains partnerships with law enforcement, community mental health, public and private agencies, day-to-day clinical work, and barriers to sharing information across agencies present dilemmas not adequately addressed or covered by law. In order to effortlessly implement the coordination care aspect of a CIT model, changes in this particular area must be addressed.

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## 6.8 Interactions with Probate Courts and the Criminal Justice System

Outpatient commitment is a court order for any individual who meets the legal criteria to comply with outpatient treatment that typically involves medications. Outpatient commitment acts as a preventative measure to ensure that a person with a psychiatric illness that requires treatment to remain stable, who is not currently, imminently dangerous, receives their treatment as required.

CITs throughout the United States are likely to come in contact with patients who are committed to outpatient treatment. In the United States, all but five states

have laws authorizing outpatient commitment, although these standards vary by state [35]. CIT personnel need to be knowledgeable with respect to compliance enforcement, as well as the circumstances for outpatient commitment, inpatient hospitalization, and voluntary outpatient services. Outpatient commitment has resulted in reduced recidivism rates to EDs and inpatient psychiatric admissions, a reduction in total hospitalization stays and service costs for persons with mental illness, improvements in social functioning, increased quality of life, and lower acts of interpersonal violence and arrests [36, 37]. For CITs who operate in communities where outpatient commitment is an option, this may be a useful resource.

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## 6.9 Special Considerations

Interdisciplinary coordination is at the core of the CIT model and associated with positive outcomes [38]. Having said that, it should be noted that, quite often, police and mental health professionals and agencies do not have trust in one another and also have misconceptions and dichotomous agendas which ultimately lead to barriers in providing quality patient care. Consistent and effective communication, relationship building, and ongoing training are beneficial for municipalities implementing a crisis intervention team.

CITs are also likely to encounter patients with neurodevelopmental disorders and developmental disabilities. While the CIT training program includes what appear to be brief didactics on cognitive disorders, there is currently no module on neurodevelopmental disorders. The prevalence of developmental disabilities and neurodevelopmental disorders in children in the United States has increased by 17.1% between 1997 and 2008 [39]. Individuals with developmental disabilities and neurodevelopmental disorders can present with behaviors that require individualized approaches for effective intervention. Such individuals have multiple challenges that include barriers to communication, poor adaptation to change in routine or environment, excess unstructured time, increased sensitivity, and difficulty expressing physical complaints such as fatigue or hunger. Their inability to effectively communicate their issues or needs can lead to a situation that escalates as a result of their behavior. Without specialized knowledge and training in the area of neurodevelopmental disorders, the CIT may inadvertently escalate this special population or transport them to the ED for further evaluation when neither of these outcomes may be appropriate or necessary.

Another common challenge faced by CIT in field responses centers on issues around the patient's competence as it pertains to the refusal of medical care related to psychiatric illness. The topics and questions that surround competency and the capacity to make decision are widely misunderstood. This not only causes confusion during field responses, but can lead to an inadvertent violation of patient rights by CIT personnel. The terms, competency and capacity, are often used interchangeably; however, as formally defined, capacity is judged by clinical staff, while competency is judged by legal professionals. By law, patients are allowed to refuse psychiatric treatment, and health professionals are obligated to respect such refusals.

Conversely, society as a whole does recognize that people who are potentially gravely impaired, or who are imminently dangerous secondary to psychiatric illness, may express preferences that do not reflect the values, goals, or commitment they would normally endorse [40]. Patients are assumed to have decision-making capacity when it comes to treatment unless a physician demonstrates they do not by means of a formal capacity assessment or by the appointment of a guardian who is charged with making medical decisions on behalf of the patient.

It is generally agreed that determining the patient's capacity is outside the scope of the CIT role. In cases where a patient's capacity is questioned during a mobile outreach, as long as there are no concerns of potential imminent dangerousness secondary to psychiatric illness (including grave impairment), a referral should be made to a physician to conduct an outpatient capacity evaluation, followed by rapid referrals to appropriate outpatient services, and follow-up by the CIT as needed. In light of this particular challenge to CIT responders, specialized education, training, and procedures related to this complex topic would be advantageous for the responders.

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## 6.10 Summary

With its streamlined process from police dispatch screening calls to a tandem team of a trained mental health professional and police officer evaluating the patient in their own home, the CIT model offers patients specialized and the least intrusive level of care possible. Areas of diversity that occur with CIT programs include the disintegration of the CIT model once a patient arrives in the ED due to organic processes within each local ED and the genesis of additional CIT model variants that can lead to disorganization and breakdown when trying to execute response using the desired model. Despite these challenges and nonstandardization, the CIT model has the ability to reduce overcrowding in EDs and allows police departments to target psychiatric crisis calls for prompt return to law enforcement duties. For patients who suffer from psychiatric illness, the CIT model offers timely assessment and, when appropriate, links to community health agencies for treatment outside the stormy walls of the ED.

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# Alternative Models of Emergency Psychiatric Care: Regional Emergency Psychiatric Facilities, Freestanding Emergency Departments, and Urgent Care Centers

7

Shawn E. McNeil

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## Abstract

A variety of different models are now available for the treatment of patients experiencing psychiatric emergencies. In some areas, there are regional psychiatric emergency facilities. In most areas, there are freestanding emergency departments (ED) and/or urgent care centers. Regional psychiatric facilities have features in common with other psychiatric emergency services that have been discussed. There is less evidence regarding the psychiatric patient in freestanding emergency departments and urgent care centers. Some unique benefits and challenges should be considered when utilizing these facilities. Freestanding EDs and urgent care

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centers can function in more remote locations than traditional EDs; therefore, they extend the reach and impact of the medical establishment to more secluded populations and provide more opportunities for treating individuals who would otherwise have limited access to treatment facilities. Regional psychiatric emergency facilities will have psychiatrists available; however, the presence of specialized psychiatric care is less likely in freestanding EDs and urgent care centers. The increased use of telemedicine has made specialty care available to remote locations and, when used, can bring the expertise of psychiatric specialists to EDs and urgent care centers not physically staffed by mental health providers.

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## 7.1 Introduction

Given the backlog of patients (especially psychiatric patients) in traditional emergency departments (EDs), a variety of different models have developed to meet the need of the individual in a mental health crisis.

The “Alameda model” (named after a series of community hospitals in Alameda County, California) serves as a blueprint for regional emergency psychiatric facilities. The facility consists of a freestanding psychiatric inpatient unit and the regional emergency psychiatric unit [1]. Patients may present to the facility from other EDs in the region, via ambulance, via police, or they may self-present. As the facility accepts all transfers from other EDs, they meet federal EMTALA (Emergency Medical Treatment and Labor Act) requirements (see Chap. 1). As the patients are evaluated and treated, up to 75% of the patients in crisis may be stabilized and discharged at this level of care. Another benefit is that patients who might otherwise be boarded in emergency departments can be transferred to these regional community psychiatric facilities [1, 2] which can, in turn, reduce boarding time by up to 80% for those patients in need of psychiatric care. Another regional psychiatric unit is in Tucson, Arizona. Over 1000 adults and children are seen in the unit every month; over 66% do not require inpatient hospitalization after stabilization [3].

Freestanding emergency departments (EDs) have developed as an important component of the overall healthcare system. These facilities have emerged to provide emergency care to communities that do not have the infrastructure or resources to support hospital-based emergency departments; some of these facilities are hospital affiliated, while others are completely independent [4]. The number of freestanding emergency departments has been increasing; there were 360 in 2017 with a majority located in Texas [4]. The services provided by these units can be valuable to communities with limited options for emergency and acute care. In addition to providing emergency medical care, these facilities may also be tasked with providing emergency psychiatric care. Compared to hospital-based EDs, however, fewer visits to freestanding EDs are for the treatment of mental illness [5]. In contrast to the fact that most freestanding EDs aren’t focused solely on psychiatric care, Carolinas HealthCare Systems has a large freestanding psychiatric ED [6].



Urgent care centers are rapidly increasing in the USA; the Urgent Care Association found that the number in November 2018 was almost 9000 [7]. One of the main complaints of any individual presenting to a traditional hospital-based ED is the delay in assessment and treatment. In contrast, most patients (almost 90%) of those who present to urgent care centers wait less than 30 min to be seen [7]. Urgent care centers may be affiliated with a hospital system or nonhospital affiliated [8]. They may be staffed largely by mid-level providers (advanced nurse practitioners and physicians assistants) or a combination of physicians and mid-levels [8]. Ho et al. found that the costs for urgent care centers are much lower than the costs for freestanding and hospital EDs [9]. While most urgent care centers do not focus solely on psychiatric care, the *American Psychiatric Association Task Force Report and Recommendations Regarding Psychiatric Emergency and Crisis Services: A Review and Model Program Descriptions* describes psychiatric urgent care facilities as one aspect of emergency psychiatric services and gives recommendations for staffing and regulation [10].

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## 7.2 Liabilities and Capabilities of These Systems

Regional psychiatric emergency systems accept patients from emergency rooms, ambulance, police, and walk-in patients. Thus, they provide relief to an overburdened hospital ED system. Patients are more likely to see a psychiatrist and receive the appropriate care; the amount of time the patient waits for a psychiatric bed in the ED (“boarding”) is decreased and the patient is more likely to receive needed inpatient or outpatient care. As the psychiatric patients are no longer filling medical/surgical beds in the ED, medically ill patients can receive care; otherwise, these patients and the income they would generate are diverted to other EDs.

Freestanding EDs and urgent care centers have several features that make them unique in the delivery of psychiatric care. They can exist in smaller communities that would not otherwise support a large medical center, which expands the reach of the medical centers to remote locations. Freestanding EDs are typically able to provide a higher level of care than so-called “urgent care” facilities, which are becoming more commonplace. A higher level of medical management can also be achieved in the freestanding ED if a psychiatric patient has a medical emergency or needs medical attention.

These freestanding emergency departments are typically either hospital owned or privately owned. They are usually open 24 h a day, which may be mandated by state law. These facilities have the resources to treat most emergencies; however, trauma cases are usually brought to hospital-based EDs. Freestanding units frequently have limited staff. Although these units cannot keep a patient for a long time, they are often within 15–20 miles of a hospital which can accommodate patients that need observation or admission. These freestanding EDs boast a shorter average wait time than other EDs with a total throughput time of 90 min compared to 180 min for hospital-based EDs [11].

Urgent care centers are limited in the services they can provide. They may be likely to refill psychiatric medicines or treat uncomplicated depression or anxiety;



staff will probably refer more complicated cases, such as those requiring extensive medical workup or inpatient psychiatric care, to the nearest hospital-based ED. As noted above, the average wait for evaluation in an urgent care center is less than 30 min [7], and the costs are less than that of freestanding EDs or hospital-based EDs [9].

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### 7.3 Limitations of These Systems

Since regional psychiatric emergency facilities accept patients from the emergency medical services, police, and self-referral, these patients will not have the medical clearance that a patient from a hospital ED has. Though Trivedi et al. found that less than 1% of individuals evaluated at a regional psychiatric emergency center required transfer to a hospital ED [12], there are still a few individuals who will need referral to a medical center for medical evaluation.

Not all psychiatric patients presenting to the emergency department are experiencing a true emergency. In these cases, using a hospital ED can involve unnecessary costs and delays. Regional psychiatric emergency services have the capability to assess, treat, and either discharge or admit the patient to an inpatient unit. These patients can potentially be evaluated and treated in a freestanding ED or urgent care center. For those who need inpatient psychiatric care, taking the patient to be seen in a nearby freestanding ED or urgent care center with no psychiatric inpatient unit may add costs and delay specialized care when the patient could have been routed directly to a medical center with both medical and inpatient psychiatric services. Most states require that freestanding EDs meet the EMTALA criteria; a patient exhibiting suicidal behavior at a freestanding ED must be transferred to a higher standard of care, such as an inpatient psychiatric unit, which can result in “boarding” in the freestanding ED [11]. Freestanding psychiatric EDs such as the one in North Carolina can transfer patients to an inpatient unit (or may have an associated inpatient unit) or establish outpatient follow-up.

The involvement of additional facilities also creates more handoffs, which increases the opportunity for medical errors and miscommunication of patient information. Freestanding EDs or urgent care centers are usually limited in the extent of services they are capable of providing as compared to an ED that is part of a large medical center; a hospital ED has a greater likelihood of having specialized staff, including psychiatrists. Freestanding EDs and urgent care centers may not be equipped to handle certain acute psychiatric scenarios. For example, agitated patients may benefit from seclusion or a safe and monitored holding area that may simply not be available in some freestanding EDs or urgent care centers.

The increased complexity of certain psychiatric cases dictates that more time may be needed for the assessment to take place. Hospital EDs usually rule out acute medical complications as well as manage psychiatric symptoms. Often, the throughput time is extended and “ED boarding” occurs. The complication with this scenario is that patient decompensation is more likely with more time spent in the ED [11].

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## 7.4 Personnel and Staffing Needed

Regional psychiatric emergency services will have personnel similar to those required for a psychiatric emergency service adjacent to a medical ED. Full-time psychiatric staff (which may include psychiatric residents), nursing staff (including licensed nurses and mental health technicians), therapists, social workers, and addiction specialists all contribute to the comprehensive care which the psychiatric patient receives. Peer support personnel (individuals with a history of mental illness who have received training for this role) may also be present.

At a minimum, a freestanding ED or urgent care center should employ emergency medical staff who can address the medical needs of the patient and are also able to treat acute psychiatric conditions. These facilities may have limited additional staff including a registration clerk, nurse, and perhaps a radiology technician and a phlebotomist [11]. The facilities may have telepsychiatry possibilities for the psychiatric patient; alternatively, psychiatrists may be on staff and used on an “as-needed” basis.

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## 7.5 Patient and Staff Safety Concerns

Psychiatric emergencies often present unique challenges to maintaining a safe and secure environment. A regional psychiatric service or freestanding psychiatric emergency unit can be loud and bustling with activity as personnel move around quickly, triaging and treating patients. There may also be the occasional influx of paramedics or other first responders transporting patients. This chaotic environment demands that attention be paid to the location and safety of psychiatric patients. Regional psychiatric emergency services and freestanding emergency psychiatric units should have security or law enforcement personnel available to screen for possible weapons. Freestanding EDs and urgent care centers may have a single security individual available at any given moment. Therefore, these facilities are less likely to have the ability to screen for weapons or provide an extensive security detail. Patients that pose a danger to themselves or others should be appropriately monitored, with one-to-one supervision being utilized if the situation demands it, in the regional psychiatric emergency service, freestanding ED, or urgent care service. While the regional psychiatric emergency service is designed to care for these individuals, freestanding EDs and urgent care centers probably lack the number of personnel needed. In these instances, the patient should be transferred to the nearest facility that can provide the necessary care.

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## 7.6 Collaboration Needed

Care in any facility requires collaboration with family or friends who can provide collateral information, previous treatment providers, and those providing psychiatric care after the emergency visit. Regional psychiatric emergency facilities have

social workers and case managers who can obtain prior inpatient or outpatient treatment records and arrange for either inpatient or outpatient care after the evaluation. Pharmacists may be on staff who can provide information on prior medication use to provide optimal care and to prevent any unanticipated withdrawal symptoms after discontinuation of previously prescribed medication. They may also access the state or federal prescription monitoring program (PMP) for information regarding treatment with controlled medications. Collaboration is necessary with the medical emergency center, police, or emergency medical service who transferred the patient to the facility. Collaboration is necessary between all the disciplines providing care to the patient: nursing, psychiatric, social work, laboratory, and medical.

In freestanding EDs and urgent care facilities, collaboration is also necessary with those who accompany the patient, prior treatment providers, and pharmacies. The physician will likely be the individual accessing the PMP, and if the patient requires transfer to a higher level of care, EMTALA requires physician-to-physician communication [11]. Nursing or clerical staff can help arrange outpatient psychiatric care if the patient returns home after the visit.

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## 7.7 Expertise Needed

Regional psychiatric emergency center personnel should have experience in psychiatric facilities and receive regular training in de-escalation and violence prevention techniques and management of agitated or suicidal patients. Psychiatrists or psychiatric residents with supervision should be available 24/7. Security members also need training in how to handle agitated patients, including the ability to safely restrain a patient.

As previously mentioned, the freestanding ED or urgent care center should have psychiatric expertise available either by agreements with psychiatrists or through the use of telepsychiatry. Nursing and clerical staff should know mental health resources available and applicable laws.

Physicians, both psychiatrists and nonpsychiatrists, employed in any facility should have an understanding of the state and country laws regarding involuntary commitment. Physicians require the knowledge of laws regarding the notification of legal personnel regarding child, elder, or adult abuse, domestic violence, and human trafficking. In some states or locales, the physician must notify the driver's license agency if there is a question regarding the capacity to drive safely, whether due to seizures, neurocognitive disorders, or other physical illness. Staff members should be educated in the delivery of trauma-informed care for patients who present after a traumatic event. All staff requires knowledge of cultural competence including LGBTQ (lesbian, gay, bisexual, transgender, questioning) issues.

All staff, in any facility, requires yearly updates in handling agitated, violent, and suicidal patients.

## 7.8 Resources Needed

The provision of acute psychiatric care in a regional psychiatric emergency unit or freestanding ED will be similar to that of a hospital-based ED. The facility will need appropriate medications for the treatment of common psychiatric conditions in addition to “as-needed” medications for acute agitation (e.g., prn). Additionally, intoxication or substance withdrawal may be a factor, mandating a need for medications to treat substance intoxication and withdrawal. Equipment necessary for acute medical and psychiatric management is also essential. The ED should have a quiet and secure space where providers will have the opportunity to evaluate patients without distraction when performing their initial patient assessment. The area where patients stay also needs to be appropriately secure, especially when the involuntary legal status of many patients in this setting is taken into consideration. Staff should have restraint options and a secure room for seclusion if an agitated patient requires this level of intervention; however, these options should only be utilized by following institutional, state, and national regulations.

Urgent care facilities need basic oral and intramuscular psychiatric medications for agitation or withdrawal. Both urgent care facilities and freestanding EDs will need medical equipment for vital signs, lab work including urine drug screens and pregnancy tests, bloodwork, X-ray equipment, and fetal heart tone monitors. Most urgent care facilities will have limited resources for seclusion and restraint. Individuals requiring that level of intervention will generally need referral to a higher level of care.

In contrast to urgent care facilities and freestanding EDs, many individuals who arrive at a regional psychiatric emergency center will have medical clearance done by the transferring emergency department. Regional psychiatric emergency units will also need medical equipment for vital signs, lab work including urine drug screens, pregnancy tests, therapeutic blood levels, metabolic panels and complete blood counts, X-ray equipment, and fetal heart tone monitors.

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## 7.9 Considerations of Coordination of Care

The freestanding ED or urgent care center will not typically be the final destination for patients in need of acute psychiatric care. After the initial workup and treatment are underway, these facilities will need to coordinate the transfer of the patient to a facility with an appropriate level of care. If medical issues are a concern, the patient may need to go to a medical unit or an intensive care unit (ICU). Otherwise, many patients will need to go to an inpatient psychiatric unit. Some patients will be able to be discharged after their assessment and/or treatment is complete in the freestanding ED or urgent care center and will require referral for appropriate outpatient care. In these cases, social workers or nursing staff typically are crucial in making such arrangements. A portion of those deemed suitable for discharge with outpatient care follow-up will need to be discharged with a sufficient supply of their medications. This supply should last until outpatient follow-up has been attained.

Regional psychiatric emergency units will need to coordinate with the transferring ED, police, or emergency medical personnel who referred the patient. They will either treat the patient in the unit and discharge to outpatient care or transfer to an inpatient psychiatric care unit. Social workers usually make arrangements for outpatient psychiatric or substance abuse care or facilitate transfer to an inpatient psychiatric or substance rehabilitation facility. Discharged patients will need a supply of medication to last until the follow-up psychiatric appointment. In all cases, follow-up care should ideally be within a week of discharge from the regional psychiatric emergency unit, freestanding ED, or urgent care center.

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## **7.10 Interactions with Probate and the Criminal Justice System**

The acute nature of the ED means that, at various stages, law enforcement is often involved. First responders are usually responsible for transporting patients in crisis to the regional psychiatric emergency unit or freestanding ED, and law enforcement officers require training to manage patients who are intoxicated, or otherwise under the influence of a substance, and/or who are suffering the effects of mental illness. They may also be involved in the confinement or restraint of agitated patients, the transfer of patients within the facility, and the transportation of patients being transferred to another facility. As an alternative, the ED or regional psychiatric emergency unit may have separate security or law enforcement detail that handles the patients within the facility.

Additionally, the criminal justice system may be involved in various aspects of a patient's acute psychiatric care. Depending on the length of stay in the ED and the state where the facility is located, the patient may need a court order that involuntarily remands them to a psychiatric facility after an involuntary hold time period has elapsed. Courts may also be responsible for a patient's presence in the regional psychiatric emergency unit in the first place. For example, patients who violate a court order to report for outpatient psychiatric care may be ordered by a judge to be brought by law enforcement to the ED for psychiatric evaluation.

Police may bring individuals in custody to the regional psychiatric emergency unit for evaluation and treatment. Individuals in custody may present for psychiatric evaluation to either a freestanding ED or urgent care facility in rural areas. All facilities should have provisions regarding the care of the patient in custody.

---

## **7.11 Security Needed**

Many freestanding EDs or urgent care centers do not have security personnel, which further increases the risk of negative consequences, including patient violence [11]. Although there may be no requirement to have security on-site, the facility should have a protocol for dealing with security concerns.

In contrast, law enforcement will often transport psychiatric patients to the regional psychiatric emergency unit. Agitated, violent, and suicidal patients are more likely to be in the regional psychiatric emergency units. Thus, these units are more likely to have full-time security staff, panic buttons, and video monitoring.

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## 7.12 Special Considerations

Regional psychiatric emergency units are currently located in three states: California, Arizona, and Oregon [3]. The growth of such facilities may be dependent on adequate financing through the Medicaid and Medicare systems or special rate codes [2]. Funding drives models of treatment, and even though the benefits in cost savings may be tremendous, newer models may not develop without the promise of a steady revenue stream.

Although freestanding EDs are becoming more commonplace, they are concentrated in a few states now. In three states (Texas, Ohio, and Colorado), communities with more private insurance, higher median income, and higher population growth are more likely to have a freestanding ED [4]. This trend is driven both by the economics of running such a facility and by the regulations that impact this industry. It is, perhaps, too early to tell if these facilities will provide relief to overcrowded, urban emergency departments, or if they will draw commercially insured customers away from conventional emergency departments, thus providing competition in the market [13]. In the future, the creation and expansion of freestanding EDs should be guided by a policy that will embrace the principles of justice and equity to ensure fair availability.

The number of urgent care facilities continues to increase. Given the fact that patients spend less time waiting to be seen and the cost is less [8], one can expect the trend to continue.

Due to the presence of psychiatric staff, regional psychiatric emergency units are better suited to the care of the mental health needs of children, adolescents, and those with autism spectrum disorder. In contrast, as freestanding EDs and urgent care centers do not necessarily have psychiatrists available to “consult” in these units, they are less suited for those psychiatric patient categories. The use of telepsychiatry may help; however, many of these patients will likely face a possibly unnecessary transfer to specialized inpatient psychiatric units where they can see child and adolescent psychiatrists or psychiatrists who specialize in autism spectrum disorder.

---

## 7.13 Summary

Regional psychiatric emergency units provide a distinct and necessary service to the communities they serve. Psychiatric patients may arrive from other EDs, with the police or by ambulance, or walk-in. They receive an evaluation, treatment, and

either referral to inpatient or outpatient psychiatric facilities for further care. For these communities, these units provide care to the psychiatrically ill who might not receive acute care otherwise.

Freestanding emergency departments (EDs) and urgent care centers are settings that have been growing in popularity around the country. These facilities can operate in smaller communities that might not otherwise have the resources to support a large medical center. As such, they can function as part of the “front line” in serving a community’s medical needs, which include psychiatric services. Patients in psychiatric crisis or acute substance intoxication or withdrawal may be more readily served by a freestanding ED with the option of transfer to a higher level of care (such as an inpatient psychiatric unit) as necessary. Although this may represent an extra step for a patient bound for higher levels of care, these freestanding ED facilities and urgent care facilities can often initiate care quickly as well as provide an opportunity to triage and assess patient severity before further decisions are made.

Regional psychiatric emergency units, freestanding EDs, and urgent care centers can offer relief to the overcrowded hospital ED and provide triage and treatment to the psychiatric patient who could wait days to see a psychiatrist in a hospital ED. Thus, these innovations represent progress and needed components in the care of the emergency psychiatric patient.

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# Transition Clinic: Reducing Recidivism

8

Cheryl McCullumsmith, Raisa Tikhtman,  
and Stephen C. Benoit

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## Abstract

Rapid outpatient follow-up for patients who present to psychiatric emergency rooms is critical to improve psychiatric outcomes and reduce recidivism. The stabilization, treatment, evaluation, and disposition (STEDI) clinic model is a transitional clinic designed to provide follow-up for patients within 1–2 days of psychiatric crisis and to support patients through stabilization and medication management until they have established a psychiatric home. The successful implementation of the STEDI clinic requires collaboration among several community stakeholders, in addition to the human and physical resources necessary to operate the clinic. In this chapter, the authors discuss the benefits, limitations, and other key features of the STEDI clinic model.

## 8.1 Introduction

Rapid follow-up after psychiatric crisis can prevent hospitalizations, improve patient care, and reduce recidivism [1–3]. Because a lack of aftercare has been predictive of short community tenure after a psychiatric emergency department (ED) visit, rapid follow-up after emergency room visits is crucial, not only as a matter of general concern but for behavioral health concerns [4, 5]. Patients often present to emergency rooms and hospitals in psychiatric crisis because they cannot access psychiatric appointments in a timely manner, and the opportunity to find rapid treatment after their psychiatric crisis visit can be problematic. Many of these patients do not qualify for treatment in community mental health clinics because diagnoses of substance use, depression, or anxiety disorders often do not meet the criteria for “serious mental illness.” Patients interviewed after a psychiatric crisis identified the following needs:

1. A follow-up phone call within a few days.
2. The ability to identify and avoid triggers for future episodes.
3. Encouragement about their chances of recovery.
4. A follow-up visit scheduled with a primary care provider (PCP).
5. Referrals to peer support groups.
6. Assistance with paying for medications [6].

These patients are particularly disadvantaged in systems that place the onus on the patient to navigate the often convoluted, illogical, and underserved pathways to outpatient services [7]. In the United States, fewer than 40% of patients hospitalized for psychiatric illness follow-up with outpatient mental health services after discharge into the community, while nearly half are hospitalized again in the same year [1, 8–10]. For adults on Medicaid, psychiatric diagnoses (e.g., mood disorders and schizophrenia) are the two most common reasons for hospital readmission within

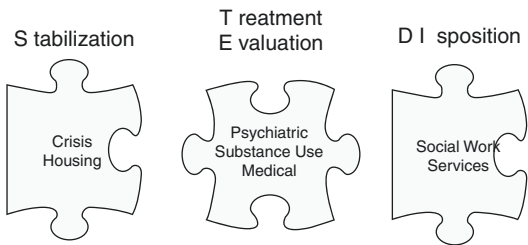
30 days post-discharge; as a result, the overall cost to the Medicaid system in the USA in 2011 was approximately \$588 million USD [11]. Delays between discharge and outpatient follow-up increase the risk that patients will stop their medication regimen, attempt self-harm, or disconnect altogether from mental health services [12]. Conversely, attending at least one outpatient appointment after discharge has been observed to reduce one-year patient rehospitalization rates [13].

## 8.2    Transitional Clinic Models

Several models of rapid access follow-up transitional clinics have been reported. Ohio State University has reported on a clinic model called Crisis Assessment Linkage and Management, or CALM [3], which decreased ED visits and the length of hospital stays by about 32% while providing improved care for patients in psychiatric crisis.

One of the authors implemented and devised the acronym STEDI for stabilization, treatment, evaluation, and disposition (Figs. 8.1 and 8.2) at the University of Cincinnati. The basic premise of the STEDI clinic is to provide care within 1–2 days of discharge from the emergency room in order to evaluate the patient’s stability, identify barriers to treatment engagement, and help the patient connect to their permanent psychiatric home. From the emergency setting, this model can reassure providers that the patient will get a rapid post-discharge appointment, which can further enable prescribing medications, or the ability to check on labs for medications that need monitoring. The STEDI clinic model is to call and check on all patients who do not arrive for their follow-up appointments and to call care managers and family members approved by the patient in the emergency setting. Patients are given the STEDI clinic appointment time and date at the time of discharge from the emergency room, along with bus tokens to assist them in getting to their appointment, if needed. Patients are counseled that this appointment is part of the continuity of care with their primary psychiatric care provider and that the clinic does not provide any controlled substance prescriptions. The STEDI clinic is able to review or order labs, give injections, and monitor follow-up via phone or in person visits. Clinicians will also notify police or a mobile crisis team if the patient is at high risk and is unable to be contacted (Fig. 8.2). At this clinic, the clinician has a copy of the note from the emergency department or psychiatric emergency services (PES) and the goals of care as well as the follow-up psychiatric appointment date; diagnoses and treatment

**Fig. 8.1** STEDI clinic model



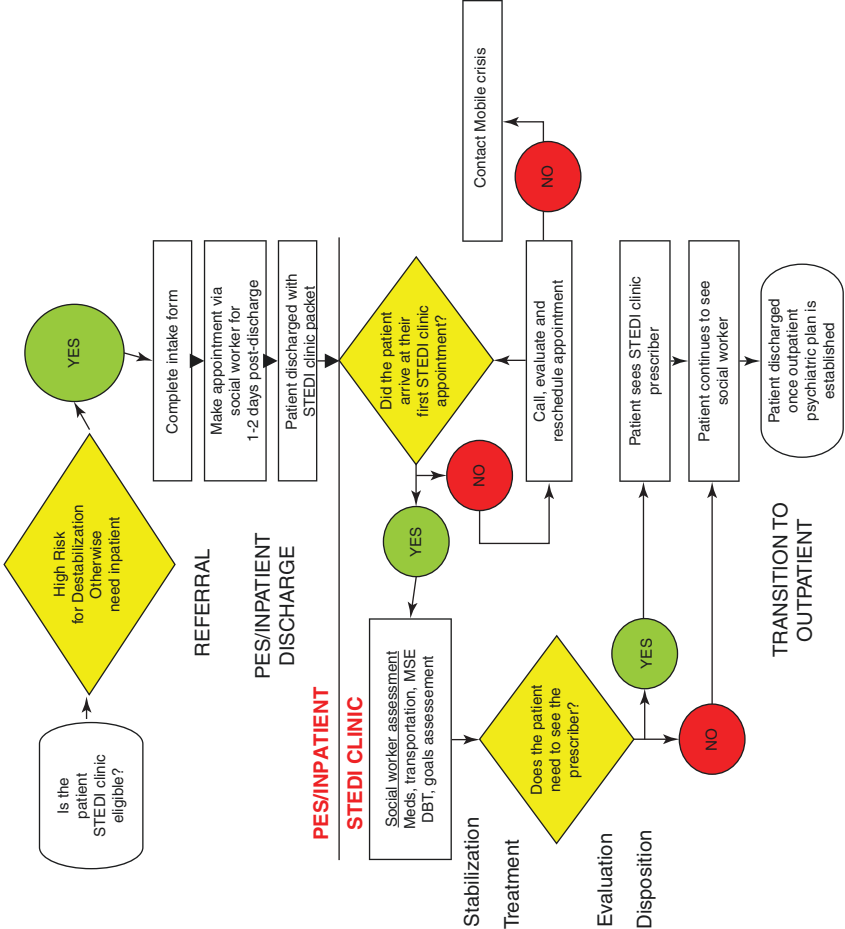
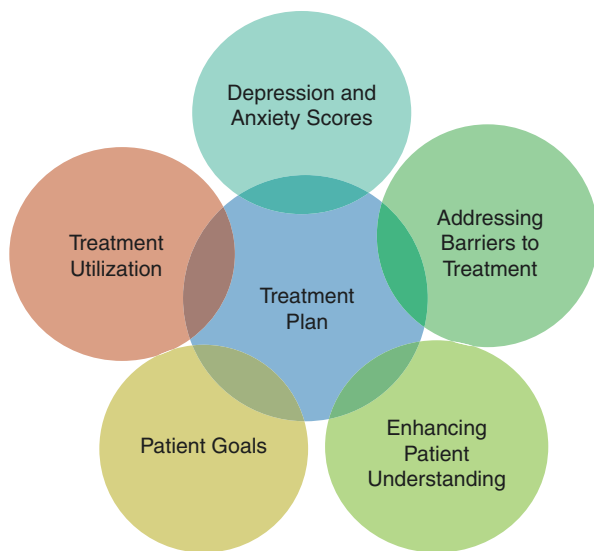


Fig. 8.2 STEDI clinic flow

**Fig. 8.3** Treatment plan development in the STEDI clinic



goals can be updated as needed at the follow-up appointment. The STEDI clinic assists in continuing and advancing the patient's treatment plan by identifying barriers to the plan, reinforcing the patient's strengths and goals, and identifying areas that need focused attention, including medical, substance use, and social concerns (Figs. 8.3 and 8.4).

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### 8.3 Liabilities and Capabilities of This System

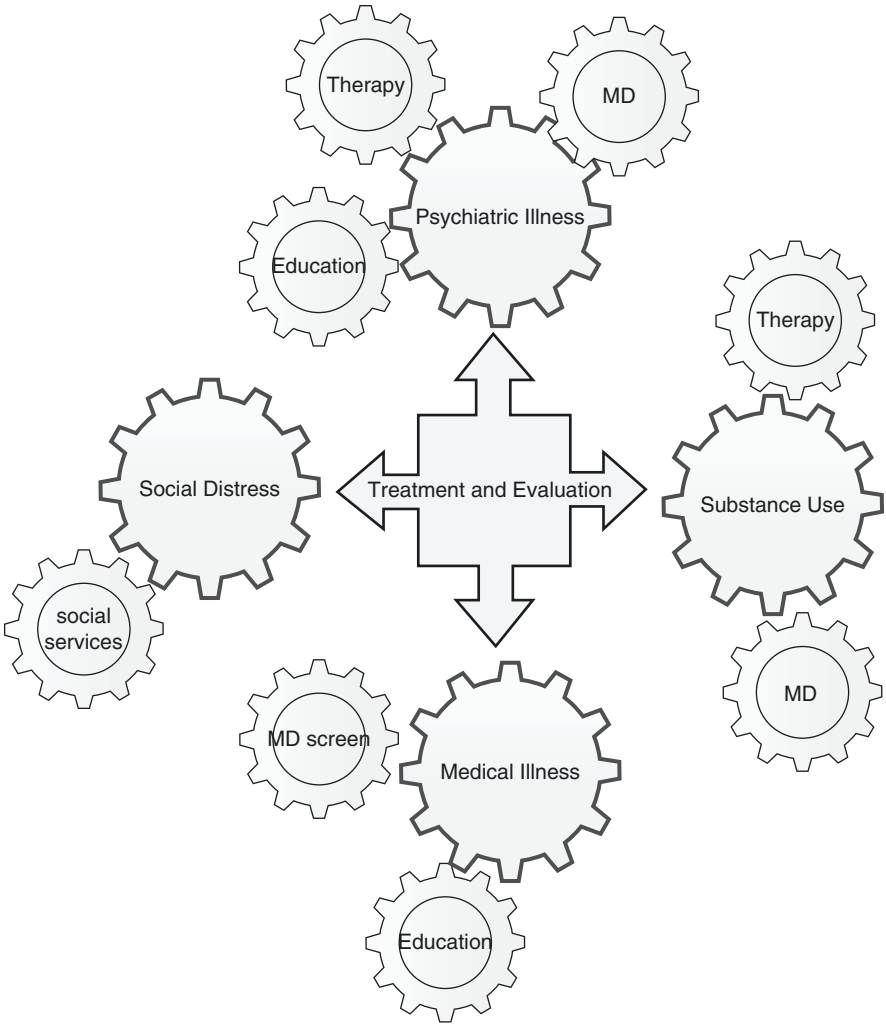
Transitional clinics can play a critical role after a psychiatric crisis to ensure patient stabilization, provide medication management which decreases the need to return to the psychiatric emergency service (PES), and offer effective transition to long-term care. Through this support, PES revisits within 1 month, and patient admission to inpatient services can be reduced.

Liabilities include high no-show rates for transitional clinics and the time-consuming need for constant communication with the emergency services. Finally, the clinic requires a financial investment from the primary health system, due to lack of patient ability to pay.

---

### 8.4 Limitations of the System

The primary limitation of the system is the lack of patient comprehension of the clinic's purpose. Problems may include a lack of communication between PES and long-term care and the lack of contact between the patient and transition clinic. Additionally, the clinic is not a long-term care solution; some patients become comfortable with the transitional clinic and do not want to move on to long-term care.



**Fig. 8.4** Multidimensional goals of the STEDI clinic

Finally, the rate of patients scheduled per day depends on how many patients are discharged from PES, which results in a fluctuating rate of daily patient visits.

### 8.5 Personnel and Staffing Needed

Personnel essential and dedicated to the clinic should include a social worker, as well as a prescriber who is a psychiatrist, PA (physician’s assistant), or CNP (clinical nurse practitioner). Laboratory facilities, a scheduling coordinator, and security should also be available. Depending on the size of the clinic, a therapist and a medical assistant are also useful (Table 8.1).

**Table 8.1** Personnel and staffing needed for the STEDI clinic

Dedicated to clinic	Social worker
	Prescriber (psychiatrist, CNP, PA)
Available to clinic	Scheduling coordinator
	Security
	Laboratory services
Optional, but useful, depending on the size of the clinic	Therapist
	Medical assistant

**8.6 Patient and Staff Safety Concerns**

Patients are seen at the transition clinic after an emergency room visit. There is a real possibility of violence or suicidal/homicidal ideation in these patients. Standard hospital security staff must be in place to maintain limited access to the facility (which includes a secure entrance with badge access) and to transport patients to the emergency department if needed. A well-defined security protocol that utilizes code words for different types of dangerous scenarios must be implemented.

**8.7 Collaboration Needed**

Collaboration between the transition clinic and the emergency room is critical for adequate communication about patient information, documentation, and appointments. The clinic’s success in transferring care also depends on collaboration with the patient’s outside PCP, psychiatrist, therapist, and/or psychologist, depending on the needs of each individual patient. Ideally, all of this will occur before or during the patient’s first visit to the transitional clinic. Additionally, the clinic collaborates closely with multiple community stakeholders, which include those that address transportation, housing, social needs, and legal and medication assistance.

**8.8 Expertise Needed**

All clinical staff at the transition clinic need experience and training in mental illness and, ideally, some knowledge of substance use disorders. The social worker must also have extensive knowledge of community resources.

**8.9 Resources Needed**

The physical requirements for the transition clinic include equipment to measure vital signs and appropriate space for medication management and psychotherapy visits. The clinic must be easy to locate, preferably in or near the same location as the emergency setting. Financial assistance will be critical for those unable to pay, without insurance, or without legal immigration status.

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### **8.10 Considerations of Coordination of Care**

The clinic must provide information about the purpose of the transition to all PES and long-term care providers. A careful explanation of purpose to patients and family is also critical to the clinic's efforts to reduce recidivism. Finally, many patients are homeless, lack contact information or phone service, and cannot be contacted for clinic visit reminders.

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### **8.11 Interactions with Probate Courts and the Criminal Justice System**

The clinic has no special relationship to probate courts or the criminal justice system except to communicate about outpatient probate commitments if necessary.

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### **8.12 Special Considerations**

The first major special consideration is financial as the hospital must commit to funding the clinic since many patients will not be able to pay. Another consideration is the need to communicate with the patients, families, and all care providers. This kind of clinic is not currently well-known, and misunderstandings may delay patient transition to long-term settings. A third aspect is that no-show rates will be much higher than at normal clinics. Preliminary and published data have identified the patients who are least likely to show for transition appointments which include patients with alcohol and substance use disorders, those with psychosis, and young patients [4, 5].

---

### **8.13 Summary**

Rapid follow-up after a psychiatric crisis improves patient outcomes and can reduce the burden on already limited resources of emergency department care for mental health [1–3]. This chapter has detailed one approach to solving this problem, through the use of the STEDI transitional clinic for psychiatric care and rapid follow-up. The ideal transitional model will include and connect providers for all aspects of patients' biopsychosocial needs, including family, primary care, social work, psychiatry, counseling, community resources, and legal agencies as required. It may also require commitments from the larger hospital structure, and community leadership, to ensure adequate resources. The authors conclude that this approach is most likely to result in optimal long-term patient outcomes.



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## **Part II**

### **So What Do I need?**



# What Physical Facilities Are Needed: The Question of Medical Clearance in Emergency Psychiatric Settings

9

Victor G. Stiebel

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## Abstract

The topic of medical clearance has been debated for years; traditionally, the focus has been on how to most appropriately screen psychiatric patients presenting to the medical emergency department (ED) for transfer to inpatient psychiatric units. A clear dichotomy existed between medical and psychiatric issues; however, the advent of integrated care has given this issue a more complex new shape. The need for expeditious identification of acute medical illness using history, physical exam, and basic laboratory testing, needs to be balanced with the need to monitor chronic conditions that can affect psychiatric care.

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## 9.1 Introduction

The quandary began in 1977, a time when there were serious questions raised about the ability of psychiatrists to conduct meaningful physical examinations [1]. McIntyre and Romano found that only 13% of psychiatrists performed physical examinations on their inpatients, and only 8% on their outpatients. Laboratory testing was not even a consideration. At that time, the field was heavily influenced by the analytic school of thought as espoused by Freud. Medical evaluations were assigned to “medical physicians” whose role was to ensure that patients were physically stable enough for admission to a psychiatric unit, oftentimes far removed from a medical hospital. Collaboration was limited at best; there was a clear dichotomy of roles and responsibilities. This status quo remained basically unchanged until the rise of the Emergency Medicine (EM) specialty in the 1980s. In the 1990s, the newly created psychiatric emergency service (PES) was expanded to include an emergency psychiatrist (EP). This new service and subspecialty role was often present in larger emergency departments, or located nearby, working closely with the EPs. These providers were not only responsible for direct care but also served a role facilitating placement of mental health patients in appropriate settings. A hospital-based PES would have access to all of the resources of the hospital; however, a PES located off-site might have none.

There was another change occurring during this period as well. State hospital systems began shedding beds, and soon they began to close. Mental health resources were moved to hospital-based programs. This consolidation of resources in medical centers allowed for more access to ongoing medical care. The pro-forma screening of admissions became relatively straightforward and associated with an admission “process” that included laboratory testing. However, the number of these mental health beds soon began to dwindle as well, and remaining beds were often moved outside of the general hospital, though possibly still within the general hospital campus. This resulted in mental health patients still being sent to the medical emergency department (ED) for disposition, but without any clear mechanism in place to process them. By 2001, patients presenting to the ED with psychiatric complaints represented about 6% of all visits [2]. Between 2007 and 2011, the rate of ED visits related to mental health and substance abuse had increased by 15% [3]. By 2015, the National Hospital Ambulatory Health Care Data reported that this number had climbed over 7% [4] representing close to six million ED visits. The reason for this was simple: patients in crisis had to be evaluated somewhere, and EDs were easily available. This increase directly contributed to the overall crowded situations of many EDs, as they traditionally lacked the resources needed to treat this population. Aside from those few facilities with PES programs, direct psychiatric care in the ED was provided on an ad-hoc basis by various hospital-based psychiatrists, if these were even available.

Many of these patients were sent directly to the ED for the express purpose of being admitted or transferred to a mental health floor. Previously established protocols or checklists were rarely updated. By this time, mental health floors had even fewer medical resources, and everyone remembered “that one case” where a

medical illness was missed during an ED screening. The term “medically clear” was fully in vogue by the early 1990s, but there was no standardized definition for this new term. In 1994, two seminal articles [5, 6] were published that examined what medically clear actually meant. No one wanted to avoid providing appropriate care, but the burden of ordering potentially unnecessary tests, and the ensuing delays this could cause, fell on the ED. The previous dichotomy had now morphed into a triangle among the inpatient service, the ED, and the EP.

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## 9.2 Medical Clearance

A superficial look at the term “medical clearance” implies an emergency evaluation to determine whether a psychiatric patient has an active, serious medical illness that needs to be treated. Zun [7] found that EPs and psychiatrists, having different practice philosophies, essentially spoke different languages. For one set of providers, the term “medical clearance” may mean that the patient was evaluated and no medical conditions were found. For another set, it may mean that there is a known illness, but it is stable and does not need active treatment. For yet another, it may mean that there may be a medical condition that has been treated and the patient is now ready for transfer to mental health. Tintinalli [5] found that almost 80% of patients who had been labeled “medically clear” had some active, ongoing medical illness. What began as a philosophic divergence had become a clinical practice issue.

Ultimately, “medically stable” was suggested as a more appropriate term for this patient population, but even this term raised another area of complexity. Medical and psychiatric illnesses often coexist; medical illness is common in psychiatric patients, and psychiatric symptoms are common in medical conditions. A summary of the Collaborative Psychiatric Epidemiology Surveys 2001–2003 [8] noted that 25% of the adult population of the United States suffered from some form of mental disorder. Those with a medical condition constitute 58%. In the area of overlap, 68% of adults with mental disorders will have some medical condition, and 29% of those with medical conditions will have a mental disorder. Using retrospective reviews, Hall [9] and Koryani [10] found the rate of psychiatric comorbidity on the inpatient medical wards to be 40%, and these numbers have remained mostly unchanged [11].

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## 9.3 History and Physical Examination

References on the importance of the history and physical (H&P) examination are somewhat hard to find. H&Ps are what physicians do. Obtaining a thorough H&P should not be confused with the “medical screening examination,” birthed by governmental regulatory jargon. For the purposes of this chapter, the question is whether the mental health patient with stable vital signs and no reported medical problems is considered “good to go.” The history has always been the foundation of medical practice, and nowhere is this more critical than in the medical-psychiatric patient.

These patients may not think of their medical problems as relevant, or they may not be actively taking their prescribed medications for those conditions, and, therefore, they may report that they have “no medical condition” if not specifically asked. It is unlikely that they will remember the dates of recent laboratory testing. Henneman et al. [6] pointed out that the medical history alone accurately identified 43% of medically ill patients; however, one study found that only 60% of patients accurately reported their histories [12], which brings the emphasis back to the importance of the physician’s history-taking skills.

As previously noted, certain cohorts are more at risk and these groups should be identified and examined more thoroughly. In 1984, Popkin [13] pointed out that the incidence of an “organic” mental disorder in someone under the age of 20 was approximately 10%, while in someone over the age of 80, it was over 60%. The likelihood of a primary psychiatric diagnosis in the under 20 age group was over 50%, but in the over 80 cohort it was closer to 20%.

If the history is the foundation of medical practice, the physical examination provides the material with which the physician builds the diagnoses. A young healthy patient who enters the ED with no reported history and normal vital signs may not need a more detailed evaluation; however, histories may not be complete in the emergency setting. Reeves [14] looked at a sample of ill ED patients and found that 34% had not had a complete history documented, while over 40% had not had a complete physical exam. Szpakowicz [15] noted that physical exams carried out in the ED were not complete, that vital signs were only noted in 52% of patients, and that 6% had no vital signs noted. Of course, there is a huge difference between the patient who walks into the ED and the one who arrives on a gurney. Additionally, the presence of drugs or alcohol changes the entire paradigm.

Furthermore, evaluation of the psychiatric patient in the ED reveals language barriers between specialties. The EP is worried about acute, unstable, life-threatening illness. A medical exam may be cursory at best due to the incorrect assumption that full medical coverage and follow-up will be available on the mental health unit. From the point of view of the EP, routine medical tests, essentially primary care, are not needed, take time, and waste resources. To the EP, a blood pressure of 170/102 mmHg or a glucose of 310 g/dL are simply of little interest or concern; the patient is stable! The psychiatrist, however, is looking at a patient who possibly has had no primary care, may be overweight, and is likely to be a smoker. For the psychiatrist who is probably not comfortable treating hypertension or diabetes, whose unit is unlikely to be directly attached to a medical facility, and who may not even have ready access to a primary care provider, those numbers are earth shattering.

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## 9.4 Screening Tests

With all of these variables to consider, much has been written about the value of screening tools; however, screening tools are only as good as the screener taking the time to complete the screen and think about the results. Zun [7] proposed a fairly detailed single page checklist that prioritized history, vital signs, and a focused

physical exam. Shah [16] examined a sample of 500 patients in 2012 and determined that if the following five conditions were met, then the patient could go directly to mental health with no testing: (1) stable vital signs; (2) no psychiatric history, or under 30 years of age; (3) oriented to person, place, time, and situation, or with a Folstein Mini-Mental State Exam (MMSE) over 23; (4) no acute medical problems; and (5) no visual hallucinations. The Triage Algorithm for Psychiatric Screening proposed by Miller et al. [17] looked at: (1) age less than 65 years; (2) normal vital signs; (3) no concurrent medical conditions; (4) no recent substance abuse; (5) no history of mental retardation; (6) no history of schizophrenia; and (7) no hallucinations. While these checklists do not offer anything that a solid history and physical would not provide, they do help to quantify the discussion and provide a standard set of points to be validated.

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## 9.5 Laboratory Testing

What testing should be ordered to properly medically screen a mental health patient? “Routine” mental health testing has come to include, at a minimum, a complete blood count, chemistry panel, urinalysis (with pregnancy), toxicology, a thyroid panel, an electrocardiogram (EKG), and a chest X-ray. However, in recent years, evidence from a growing body of literature has begun to coalesce into a more practical, clinically based approach. Of course, the bottom line will always be working with the multiple stakeholders. Ultimately, if a patient is being transferred, the accepting facility will be the final arbiter.

Henneman [6] essentially advised that, in addition to a complete history and full physical exam, a full laboratory panel including alcohol and drug screens was needed, and questioned whether a computerized tomography (CT) scan of the head and even a lumbar puncture should be part of this evaluation. Tintinelli [5], however, noted that a full history and thorough physical exam would catch the “vast majority” of acute medical conditions, and that routine laboratory testing was not needed. In 1997, Allen and Currier [18] essentially concurred suggesting that most testing should only be done if clinically appropriate. Olshaker [11] also felt that testing should be done based on a review of the vital signs, and a focused history and physical. In 2017, the American College of Emergency Physicians issued a clinical policy statement noting that testing should be guided by medical history, previous psychiatric diagnoses, and the physical examination [19]. The policy added that routine lab studies had a very low yield of positive results. These recommendations were made predicated on an awake, alert, unintoxicated patient with no significant past history.

The discussion had now moved from a simple clinical dichotomy to a slightly more complex triangle. Recently, the concept of collaborative care has been embraced; a simple medical clearance process for the mental health patient may no longer be the standard of care. The ED has become the *de facto* entry point for these patients into a complex system. To summarize, between 40% and 60% of psychiatric patients presenting to an ED have an active, ongoing medical condition that will need to be addressed in some fashion and require ongoing care [7–10].

Other medical risk factors are prevalent in the mentally ill population. Smoking is widespread, often heavy, and longstanding in nature. A sedentary lifestyle associated with institutionalization, lack of jobs or daily activities, decreased cardiovascular function, and poor diet is the norm. The incidence of obesity, metabolic syndrome, diabetes, and cardiopulmonary disease is estimated to be double that of the general population [20]. Psychotropic medications are independently associated with prolonged QT intervals [21], metabolic syndrome [22], seizures, and endocrine disorders such as hyperprolactinemia [23]. For a variety of reasons, compliance with taking medications is often less than ideal.

Despite the evidence that the yield of routine laboratory testing is very low and not cost-effective, these medical conditions will require ongoing monitoring and management regardless of where the patient is sent. In addition, most mental health units still have a very limited ability to order X-rays, electrocardiograms (EKGs), or even obtain emergency blood draws. It is entirely possible that if the much maligned “routine” tests are not done in the ED setting, it could be days before they can be performed, if they are done at all. One could therefore conclude that the basic parameters discussed so far have now shifted. The facilities should be available to allow laboratory testing as needed. More extensive testing should be considered for even the apparently healthy mental health patient. All of the routine tests discussed above may provide a valuable baseline for the accepting mental health team. A lipid panel, even if the patient has not been fasting, can shed light on an occult condition. Liver function testing, including ammonia levels, should be considered in view of the extensive hepatic metabolism of many psychotropic medications. Hemoglobin A1c levels can highlight a patient at risk for diabetes. An EKG to establish a baseline for possible QT prolongation is reasonable. A chest X-ray should be considered in any patient who smokes. Certainly, the blood levels of medications being administered should be drawn.

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## 9.6 Summary

In summary, this chapter has traced how a clear dichotomy of clinical care and professional responsibilities changed into a triangle and has now morphed into some complex geometric figure. The emergency physician and the emergency psychiatrist in many ways now perform gatekeeper functions and need to be cognizant not just of emergency care, but also of at least some of the ongoing care that this patient population may need. The ability to obtain immediate, basic laboratory testing should now be standard, and advanced testing should be available when needed. Of particular note is the fact that the history has never been as important as it is in the current medical system, and to the current discussion. A proper physical examination will always be critical in the evaluation of a mental health patient. The emergency department has truly become an integral part of the mental health team.



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# Administration in Emergency Psychiatry

# 10

Scott Simpson and Ashley Curry

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## Abstract

The success of a psychiatric emergency service (PES) depends on the expert coordination of an interdisciplinary psychiatric care team with community and non-psychiatric services. To provide the highest-quality patient care, PES administrators must make decisions regarding the scope and mission of their service while keeping in mind interested stakeholders and financial constraints. PES leaders must recruit and manage personnel who are skilled at working with the most acute patient population in psychiatric practice. In addition, quality

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improvement, education, and contributing knowledge to the field of emergency psychiatry are crucial responsibilities that ensure the growth and sustainability of emergency psychiatric care. This chapter describes common responsibilities expected of a PES director and explores the challenges and growth opportunities encountered in the path to building a successful PES.

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## 10.1 Introduction

Emergency psychiatry services must be prepared to treat a broad range of acuity and diagnoses, from providing medication refills to managing complicated detoxification for patients with comorbid medical illness [1]. The work environment is demanding, challenging, and occasionally dangerous. Operating a team capable of achieving this complex mission requires leaders who can unite a multidisciplinary team, collaborate with non-psychiatric services, and introduce clinical innovations.

Different models for practicing emergency psychiatry are described in this text. The job responsibilities of a psychiatric emergency service (PES) administrator or medical director are as varied as the clinical practice itself. Services themselves are often constructed differently; however, there are common responsibilities expected of any administrator or medical director. This chapter describes these common responsibilities with an emphasis on challenges and opportunities that persist regardless of delivery model. In this chapter, the term PES describes the full range of service models designed to provide treatment to psychiatric emergencies rather than any specific model (such as a self-contained unit).

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## 10.2 Determine Scope of Practice

A PES is constructed in response to need and context. In emergency psychiatry, demand for behavioral health expertise comes from providers, payers, or community leaders more often than patient requests. Regardless of the source of the demand, a service built to respond to that demand must reflect local resources including limitations of available staff and financing. As a result, emergency psychiatric services vary widely in their staffing and operations.

PES leaders must determine which patients they can serve and what they can do for their patients. The emergency department (ED) is a common entry point for mental health care, and many chronically mentally ill individuals receive a majority of their care in emergency settings [2]. In response to this demand, non-psychiatric emergency medicine providers manage most behavioral emergencies. Referral of care to a specialist is determined as much by the accessibility of specialty care as the initial providers' expertise. Leaders should consider the capacity of their service including the skills of staff and care environment. What role should the PES play in

triaging patients? Should the PES merely accept referrals from the community or ED or is there a role for the service to “pull” patients through proactive consultation? Will patients with substance use disorders be treated by the PES? When resources are limited, leaders should prioritize providing interventions aimed at improving the safety of patients and staff [3].

Leaders founding new services have wider latitude to consider these questions when setting goals for the service in collaboration with other partners. Administrators stepping into existing programs may consider whether the scope of practice has appropriately evolved to meet patient and clinician expectations over time—or whether those expectations have changed without adequate attention to changing the service’s processes and infrastructure.

### 10.3 Develop Clinical Policies

PES leaders are responsible for determining the need for—and then developing—clinical processes. Written policies may include criteria for referral to the unit, levels of observation for patients at risk, or expectations for evaluations. Although much medical practice requires expert practitioners to exercise clinical judgment, writing sound clinical policies is critical for the success of the service. These policies ensure that the service meets regulatory requirements, maintains a high quality of care, and supports its individual clinicians. The PES treats difficult patients in a high acuity, nuanced clinical environment. In this context, service policies protect individual providers by explicating a community standard of care and reducing decision fatigue on individual clinicians. Table 10.1 describes a brief list of common clinical processes relevant to operating a PES. Successful clinical policies must be developed in collaboration with relevant stakeholders.

**Table 10.1** Example clinical policies requiring definition by a psychiatric emergency service

Process	Sample elements
Triage	<ul style="list-style-type: none"><li>• Order in which patients are seen</li><li>• Security sweep of patient belongings</li><li>• Safety regarding patient attire</li><li>• Disposition of patient belongings</li><li>• Patient registration</li></ul>
Levels of observation for safety	<ul style="list-style-type: none"><li>• Level of observation required</li><li>• How observation levels are changed</li><li>• Determining staff responsible for monitoring</li></ul>
Required trainings by staff	<ul style="list-style-type: none"><li>• Minimum requirements expected for on-boarding</li><li>• How frequently refresher trainings should occur</li><li>• How staff should be educated on new or updated policies</li></ul>
Evaluation expectations	<ul style="list-style-type: none"><li>• Note templates that satisfy clinical, regulatory, and billing expectations</li><li>• Use of standardized symptom scales and safety assessment tools</li></ul>

## 10.4 Cultivate Relationships with Stakeholders

No PES operates in a vacuum. There are myriad persons and groups, both internal and external to the organization, which have a stake in the operation of the PES. A successful leader must identify relevant stakeholders for *every* decision and policy and actively seek input from key individuals and organizations. Interactions with stakeholders demand emotional intelligence, critical thinking, and an orientation toward service and team success while remaining patient centered in all decisions [4].

Within the PES team, there may be psychiatrists, emergency medicine providers, advanced practitioners, nurses, social workers, technicians, and/or clerks who each have a different, invaluable role in the treatment of patients. For example, a policy to change the triage process for patients must consider the actions of each team member involved in the process. To be successful, the policy should reflect the needs and expectations of every team member. Use of unit practice councils or shared governance models facilitates informed decision-making and change implementation [5].

Outside the PES, community organizations, payers, and healthcare administrators have a stake in new policies. In the case of a triage process change, how might that process affect a police officer or ambulance crew who brings in a new patient? New internal policies impact external providers less frequently, although some policies require close collaboration with those partners. Even when considering established or evidence-based practices, mental health stakeholders frequently hold quite varied perceptions of the importance and feasibility of change [6]. Case 10.1 illustrates how other services within the hospital are crucial to the success of the PES.

### Case 10.1. The Case of the Dirty Rooms

A psychiatric emergency service was examining ways to improve bed turnover. The service leaders evaluated their patient flow using Lean Process Improvement principles and convened representatives from every service that interacted with a patient including triage nurses, hospital registration, service technicians, nurses, and physicians. One nurse noted that beds were often unavailable because they had not been cleaned from the prior patient; thus, housekeeping was invited to a follow-up meeting. PES leaders learned that overnight, there was only one housekeeper for more than 100 ED beds. Moreover, some housekeepers were frightened to come onto the psychiatric unit. With this knowledge, the service leaders were able to advocate for a redistribution of housekeeping resources and provided education to the staff. When combined with other changes from the event, the service saw a 20% increase in volume through more efficient bed turnover.

Ultimately, the most important stakeholder in the operation of a PES is the patient. As all clinicians are at some point patients themselves, one can empathize with the patient perspective when considering new policies and PES operations. Patient feedback may be obtained through patient satisfaction surveys or the incorporation of peer counselors onto the team. Emergency providers should strive to fulfill patients' expectations for respect and autonomy in their treatment [7].

## 10.5 Collaborate with Community Partners

Like hospitals and emergency departments, the PES is a community resource and should be operated as such. Patients come from the community and will return to the community; just as PES clinicians must be familiar with clinical resources for their patients, PES administrators should be familiar with leaders in outside organizations who encounter their patients frequently. In the closest partnerships, there may be sharing of staff, clinical information, or money. Even looser partnerships maintained with an occasional phone call or e-mail may prove beneficial in unexpected circumstances and promote community access as in Case 10.2. A PES with mobile crisis services has no choice but to become familiar with community partners in order to respond effectively to community needs.

### Case 10.2. A Team Effort

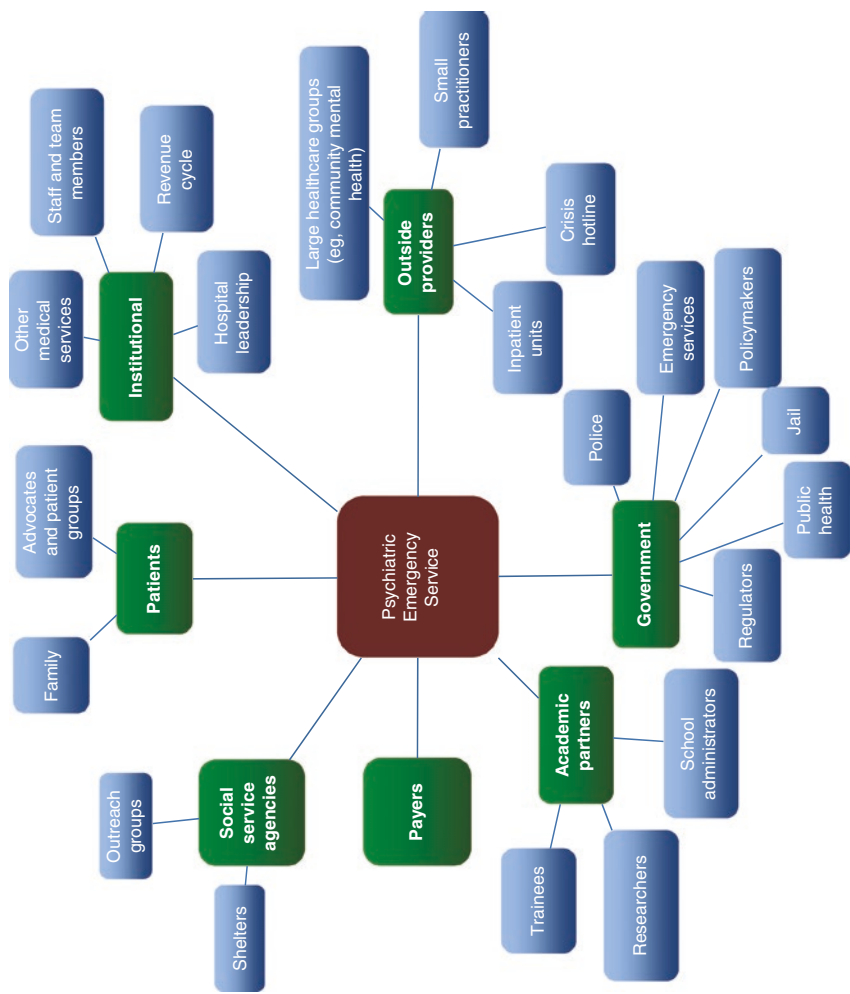
A newly recruited PES physician was interested in learning more about the social agencies utilized by his patients. Knowing that many of his patients used a large downtown shelter, he looked online, found an e-mail address, and arranged a tour. He learned that the shelter had a team of clinicians trying to help their clients, but they often felt uncertain where to refer patients with mental illness. This psychiatrist shared information about his team's mobile crisis service that could come to the shelter anytime to evaluate patients for safety and arrange same-day intake services. He also introduced the shelter clinicians to a care manager from a local public insurance organization that began screening and enrolling persons at the shelter for health insurance. Grateful, the shelter team shared information about their own programs and began accepting referrals from the hospital's ED and inpatient psychiatry unit for their long-term job placement program. As helpful as this collaboration was for this agency and psychiatry team, it was even more helpful for patients!

In many locales, a well-functioning emergency psychiatric team is a unique, valued, and high-profile commodity. Leaders should be wary that their service will be looked for by community partners to "save" treatment resistant patients or resolve long-standing systemic issues around access and quality of care. Being a vital, responsive community member requires the PES to lend its expertise while also being frank about its role, limitations, and need for working partnerships. Figure 10.1 demonstrates the range of community partners and other stakeholders relevant to the care of PES patients.

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## 10.6 Conduct Quality Improvement

Another responsibility of PES administrators is to select quality metrics that guide programming and improve the quality of care. Quality of care metrics in emergency psychiatry remain poorly defined and standardized; however, there are models to follow. Metrics should be measurable, relevant, and responsive to improvement efforts. The selection of metrics is a PES leader's opportunity to define the goals of the service [8]. For new services, program development and integration with the



**Fig. 10.1** Some stakeholders in the operation of a psychiatric emergency service



community and other emergency services may serve as the inaugural quality improvement (QI) project for the PES and can function to establish the service as an integral part of the hospital and community.

QI projects are typically initiated in response to specific, urgent issues and should be continued until the goal of the QI project is achieved or circumstances change. When conducted regularly, QI projects provide leaders an opportunity to solicit feedback from internal and external stakeholders and build a sense of camaraderie among the team. Several models exist for conducting QI, such as the Plan-Do-Study-Act cycle and Lean Process Improvement. Model selection typically depends on the nature of the issue to be addressed and personal or institutional preference [9, 10].

Publicizing and emphasizing metrics is a valuable opportunity to orient the PES team toward strategic goals. All team members should be familiar with the core metrics on which the team is evaluated and invited to share ideas for achieving that goal. The authors recommend publicly posting the most current outcome metrics to provide continuous, ongoing feedback to the team. Following-through with change efforts is a common barrier for discrete QI projects [11]. But when those projects are contextualized around a set of routinely tracked core metrics, follow-through is more easily maintained.

All PES leaders should be adept at applying principles of QI to their own service regardless of whether the service has an academic mission. Although they share analytic techniques, QI and program evaluation differ from original research in that QI activities provide specific, actionable analysis for a unit with the expectations that the unit (and ultimately the patient) benefits directly from the knowledge gained. Original research is meant to produce generalizable knowledge with external validity and may subject patients to additional risks [12].

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## 10.7 Manage Personnel

A PES incorporates a range of personnel from different backgrounds. Service administrators must design a hierarchy of supervision and reporting responsibilities that fits the service. PES team members should receive routine evaluations regarding clinical performance, communication, and professionalism. Leaders must be prepared to provide frank feedback to team members who are struggling as well as mentorship to help them succeed. All staff should also have opportunities for professional growth. For example, faculty may seek participation in administration and academic activities including protected time to foster new aspects of their career. For staff, opportunities include continuing education activities and opportunities for promotion. Cultivating opportunity for individuals to advance professionally and contribute to the service's mission enables managers to realize their most important goal—the success of the team and the service [13]. Staff-based governance models foster opportunities to integrate staff into decision-making.

Recruitment is often difficult and stressful for PES administrators. Physician faculty rarely receive comprehensive training in emergency psychiatry; psychologists and advanced practitioners are even less likely to have relevant clinical experience.

Similarly, there are not frequent opportunities for nurses and assistants to work in emergency psychiatry. When hiring staff, leaders should ascertain a candidate's relevant experience in high-acuity environments in judging their preparation for an emergency psychiatry position. A PES needs team members to practice with autonomy and at the "top of their license," but individuals must be equally prepared to work well among a diverse team in high-stress situations.

The unique environment of emergency psychiatry poses challenges for personnel management. Frontline staff working with intoxicated, impulsive, or disorganized patients are at high risk of workplace injury. Routine training and clinical processes for managing agitation improve staff's sense of safety [14]. On shift, frequent team huddles minimize the interpersonal stress in the care of severe mental illness including patients with suicidality or severe personality disorders [15]. Peer support and critical incident teams can assist staff who are feeling intense countertransference after being assaulted or emotionally impacted in a patient interaction [16]. New staff, including junior faculty and mid-level providers, may benefit from regular supervision with PES leadership. Scheduling routine meetings reinforces leaders' availability and avoids the dread of ad hoc meetings that are typically centered on negative feedback.

Although leaders must help the team process the intense emotions of PES work, clinician-leaders should be mindful to maintain appropriate boundaries; a psychiatrist medical director should never provide psychotherapy to a team member or colleague. The appropriate role is that of a work colleague or supervisor rather than a treatment provider. Leaders should be familiar with resources for employees, such as an employee assistance plan that provides brief crisis psychotherapy.

Leaders must also help team members avoid burnout. Burnout is a feeling of inadequacy and fatigue induced by persistent occupational stress [17]. Burnout is common among all health professions and particularly rife among emergency medicine providers [18]. As burnout impairs work effort and increases institutional costs, medical leaders must share the responsibility of preventing and addressing burnout with their team members [19]. Organizational strategies to reduce burnout include cultivating a sense of community among the team, recognizing unique talents of individual team members, organizing the team around a shared mission, and facilitating a work-life balance [20]. Effectiveness in the other facets of administration described in this chapter helps the PES leader reduce stress on the team and mitigate burnout.

---

## 10.8 Satisfy Regulatory Requirements

Healthcare entities are regulated by an array of institutional, local, state, and federal bodies. Supervising entities vary by location and the nature of services being provided by the team. These regulations will encompass the policies and functioning of the unit as well as the expected training and supervision of individuals on the team. PES administrators should be familiar with institutional rules, how and by whom they are monitored, and why they are in place. In the case of hospital policies, PES leaders should be prepared to advocate for their patients and team among other local

stakeholders to improve the care of their patients and promote the effective functioning of their team. Advocating for change at higher levels of governments is more difficult and most often demands political coordination, perhaps with a professional society or lobbying group. Locally, risk management and legal teams should be considered potential stakeholders in the policy decision-making process.

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## 10.9 Educate the Team

An academic PES will incorporate health profession trainees as part of their team. These trainees should receive an orientation to the team that includes a focus on safety and their role in the team. The ideal teaching rotation in emergency psychiatry places the student in a well-defined role in which they are adequately supervised [21]. Meanwhile, the rest of the team should be familiar with the student's role so that they can support the student as questions arise. It is not reasonable to expect any trainee to be immediately familiar with the peculiarities of emergency psychiatry. But it is reasonable to set expectations that students work hard in the care of patients and study to enhance their fund of knowledge. Trainees who lack direction will not only find their experience less productive but also frustrate team members who may find them an unwelcome nuisance. Crisis psychiatry is an acute, unpredictable environment; trainees who cannot take direction or present to work impaired should be immediately removed from the unit and only reintroduced with an explicit remediation plan under intensive supervision.

Even absent students, PES leaders should expect to train most new hires in the unique field of emergency psychiatry. New team members familiar with emergency work may still be unfamiliar with local peculiarities in the standard of care for patients, service workflows, or community resources available to patients. Leaders must set an expectation for continuing education that includes monitoring skills maintenance and practical support to facilitate completion. For example, faculty benefit from additional funding support for continuing medical education relevant to emergency psychiatry, and staff should be allowed to clock in for on-site trainings. This financial commitment by the service not only removes obstacles to continuing education but also imparts the importance of the activity. Faculty or staff champions may regularly present relevant material to staff, perhaps on safety assessment or trauma-informed care. In applicable settings, new staff should be trained in proper restraint and seclusion techniques and receive regular refresher training.

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## 10.10 Generate Knowledge

Emergency psychiatry is an increasingly visible and important field with an inchoate knowledge base [22]. Academic services boast greater resources for novel investigation and pursuing grant funding. These resources include the availability of successful clinician mentors, biostatisticians, and experienced staff to write and administer competitive grants. Emergency psychiatrists may partner with colleagues in emergency medicine and other fields to develop original research.

However, a service need not be located in a teaching hospital or university to generate important findings. Indeed, most emergency psychiatry happens outside of those settings, and it is to everyone's benefit that PES leaders consider how the team can contribute to discovery. A community-based team might consider partnering with more established institutions whose investigators are seeking to recruit ED patients with psychiatric illness or substance use disorders. These partnerships are consistent with the goal of inter-institutional collaboration and introduce staff to research concepts.

PES leaders may also contribute to the development of the field by providing institutional talks or submitting conference abstracts related to interesting cases, new clinical processes, or QI projects. These forms of clinical evidence garner fewer scientific accolades but nonetheless contribute to the broader body of knowledge of emergency psychiatry. At least, sharing one's experience helps other community providers treat their own patients more effectively. In return, presenters often hear helpful perspectives that can improve the treatment of patients. And involving PES staff in a presentation generates camaraderie among the team. In some instances, the ideas shared from even smaller presentations inspire more complex research projects by seasoned investigators or policy action by regulators, advocates, and lawmakers.

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### **10.11 Manage with Financial Acumen**

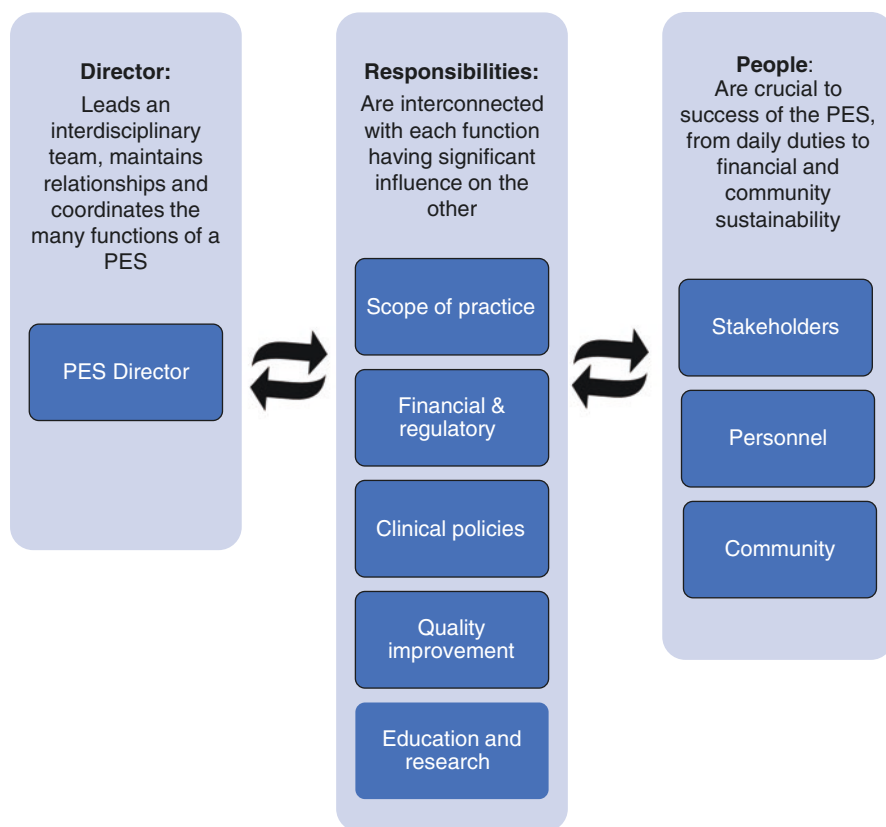
The funding environment for clinical practice varies widely by location and service type. PES leaders should be familiar with their services' funding sources and mechanisms through which compensation happens. Increasingly, even public systems are sensitive to financial management or other productivity measures. Regardless of economic or political system, psychiatric services are a finite resource whose utilization must be made available effectively and equitably. From generating policies to selecting metrics to training staff, all unit decisions implicate money and opportunity cost. See Chap. 14 for a more in-depth discussion of financial management of psychiatric services.

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### **10.12 Summary: Bringing It All Together**

No single chapter can provide an exhaustive job description, but these aspects of PES leadership are common regardless of service structure. These functions of a PES leader are also highly interrelated; Fig. 10.2 summarizes the responsibilities of PES leaders and emphasizes the interrelationship among these functions. For example, success in reducing burnout makes it easier to retain staff who is motivated to provide input on and improve new clinical policies. Success in building community collaborations expands the quality and array of services that can be provided to patients. Effectively teaching new staff and training students enhances the quality and work environment of a PES.

While leadership style varies by individual and particular service, the core mission of emergency psychiatry is universal: to deliver expert care for a challenging,



**Fig. 10.2** Summary of the leader responsibilities and relationships integral to a psychiatric emergency service

vulnerable patient population. Toward this end, success in the aforementioned aspects of emergency psychiatric administration represents success on the patient's behalf. Great clinical leaders see opportunity in every crisis and maintain optimism that there is a road to success even when the way forward remains unclear, but to attain these opportunities requires familiarity with the many functions demanded of a PES administrator.

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# Nursing Staff in Psychiatric Emergency Services

# 11

Anne C. VanderPutten

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## Abstract

This chapter reviews the knowledge and skill base of nurses in psychiatric emergency services (PES). Nurses represent the largest population of health care professionals and are a critical component of the interdisciplinary team for any psychiatric emergency service (PES). Nurse leaders are responsible for staff competency, policy development, safety, triage, and nonviolent crisis intervention. This chapter will discuss nurse-staffing ratios, quality of care, and the safety components required when providing clinical nurse care in a PES.

## 11.1 Introduction

From initial patient assessments to the development of discharge plans, nurses play a critical role in each patient's visit and stay in any hospital service, especially in psychiatric emergency services (PES). In addition to the key roles and

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responsibilities of the nurse (as outlined later in this section), the nurse provides invaluable patient support through their care delivery as the patient progresses in treatment.

Care delivery may be significantly impacted when patient overcrowding becomes an issue in any PES department. Patient overcrowding can occur at any point during care and exists when patient volume exceeds the resources available to provide timely and adequate care of the patient [1]. The capacity of any PES depends on the resources available to care for the patient in psychiatric crisis, and inadequate staff numbers can (and often do) contribute to overcrowding; therefore, ensuring an adequate ratio of nurses to patients is critical in any PES model of care.

Although models of care vary according to organizational PES practices, a nurse ratio of 1:4 patients will generally suffice to provide adequate coverage for safe and effective patient care [2]. Additionally, a trained technician or nurse's aid should be available in PES units to support nursing tasks, and to help ensure staff and patient safety. All PES staff, including nursing assistants, should receive training focused on crisis and situational de-escalation, nonviolent crisis intervention, and staff and patient safety [3]. The most common roles that nurses fill in a psychiatric emergency setting include:

1. Intake and triage—medical assessments, monitoring and recording vital signs, medications, medical conditions, and general health
2. Safety assessments—current and historical, which include:
  - (a) Violence risk
  - (b) Suicide risk
  - (c) Homicide risk
  - (d) Any potential harm or risk to children or elderly from their caretakers
3. Care of patients in the emergency room
4. Discharge instructions

The importance of a thoroughly documented triage cannot be overemphasized. Triage is a key component in any integrated quality nursing model of care; appropriate triage ensures that nursing care is consistent and efficient [4]. Further, the nurse triage addresses the acuity of presenting symptoms, and safe placement of the patient in the PES. For example, a patient who arrives in the PES with suicidal ideation and significant risk factors will be placed in a secured unit, as opposed to the patient who is presenting for follow-up care; the latter may remain in an unlocked unit location for observation. Initial intake and nurse triage assessments should be accurate, timely, and standardized to ensure patient and staff safety [5].

Nurses trained in triage understand the correct prioritization of patient care based on the severity of presenting symptoms. Suicide risk assessments should be evidence based, and policies should be established and implemented for 1:1 monitoring of patients in order to meet regulatory guidelines as outlined by The Joint Commission (TJC) [6]. Incorporating evidence-based nursing resources from professional organizations will help to ensure nurse competency when providing care for patients presenting with a psychiatric emergency [4].



Due to the comorbidities associated with patients presenting to the PES, nurse triage should be both psychiatrically pertinent and medically focused, when indicated, and standardized to maintain the goals of nursing care in a PES [4]. Later sections in this chapter discuss the ways triage assessments contribute to improving safety and quality in PES management.

---

## 11.2 Safety

Nurse leaders are not only responsible for the delivery of safe patient care, but also for developing strategies and providing trainings that ensure the safety of all PES team members. Safety concerns are inherent in the PES due to suddenly emerging and evolving crises, and rapidly changing symptoms associated with the presenting illness(es) of the psychiatric patient population [7]. Education in nonviolent crisis intervention training is critical for patient and staff safety [5]. Nursing staff are among the most affected by workplace violence, patient assaults, verbal abuse, and threats [3]. Safe and effective management of the psychiatric patient in crisis lies in prevention, and initial assessments should already have identified actual and potential safety risks, thereby allowing the nursing staff to develop and implement preventative care and safety measures before crisis escalation occurs [7]. The ability to recognize agitation and escalating behaviors is essential in maintaining staff and patient safety, and in the safe placement of higher-acuity patients [5].

The environment of care in which care takes place is also a critical component of patient safety. As patients may utilize any hardware or furniture in the unit to attempt suicide (or violence), nurse leaders are responsible for ensuring that the PES meets all the standards for safety in the environment [8]. Nurse leaders also provide training for staff qualified to conduct 1:1 monitoring for high-risk patients, and define these policies for one-to-one supervision, close observation, and precautions (suicidal, violent, hypersexual, etc.). These procedures for safe patient monitoring should be clearly defined in the organization's policy [6].

Because the expertise and experience of nurses vary, the implementation of evidence-based, standardized risk protocols and assessments is widely considered to be a best practice to maintain nursing staff efficacy and consistency of care [4]. Standardized protocols, as well as the use of suicidal and homicidal (risk) assessments, enhance:

- Patient safety—individual and other patients
- Staff safety—through crisis prevention and quality-care protocol
- Staff communication—critical high-risk patients are placed in close observation areas
- Consistent and standardized care
- Valuable information and documentation for physicians

Nurse leaders are responsible for monitoring safety and risk assessments and Fig. 11.1 represents the integral role of nurses in maintaining safety in the PES

**Fig. 11.1** Nursing relationship to PES safety



workplace [9]. As such, nurses and frontline staff should be included in any discussion regarding safety issues and any other factors that contribute to staff safety in the PES.

The effects of violence in the PES on staff and team members cannot be overstated. If ignored, these effects have the potential to negatively impact team integrity that, in turn, affects patient care and the safety of patients and staff. Successful PES leaders are proactive in establishing comprehensive stress management programs designed specifically to focus on the safety and stress associated with caring for psychiatric patients in an emergency setting. Nurse leaders may utilize resources such as employee assistance programs and team debriefs, and should provide some form of self-help training for their staff on a regular basis [4].

---

### 11.3 Teamwork

Collaboration among PES team members is a critical component of delivering safe, efficient, quality care for patients. Turner (2012) supports the use of team “huddles” or debriefs at the start of each shift, and nurses are a key member of these huddles [9]. These debriefs should include information to address current and potential issues, such as inpatient boarding, high-acuity patients, and complicated cases, in order to allow all shifts to be proactive and on the same page when planning patient care. PES teams should ensure that key roles are identified (i.e., charge nurse, social work team lead) in order to facilitate information exchange in a way that helps to minimize interruptions to providers and maintains organization among team members.

Teamwork requires the establishment of cohesive strategies for consistent quality care during peak volume in the PES. A successful patient progression model for safety management in a PES begins with nurses who are skilled in patient triage and

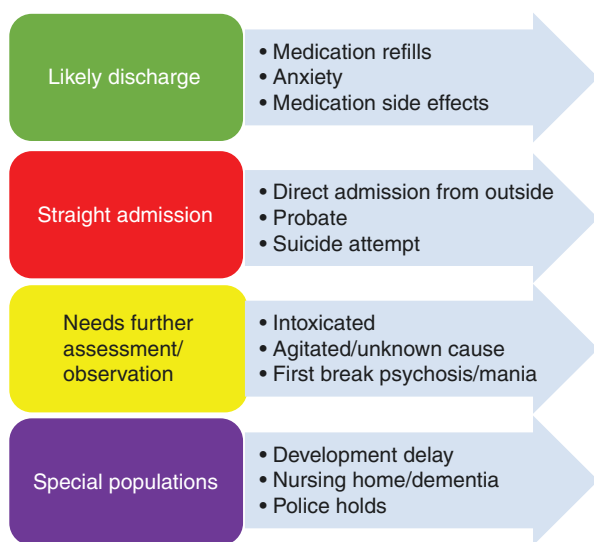
utilize a team triage approach when possible [10]. Nurses provide the initial direction for the patient's progression based on presentation and the triage assessment; therefore, they are uniquely qualified to assist the primary care provider in team leadership and in identifying the time and resources necessary for each patient based on clinical presentation.

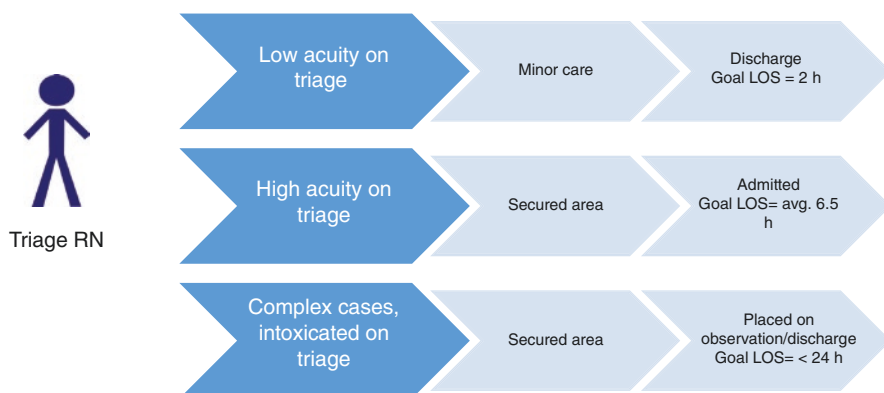
The establishment of standards of care associated with common patient presentations assists the nurse and treatment team to identify clinical pathways. Pathways may be based on anticipated time needed for nurse observation, medication administration, laboratory needs, and expected length of stay (LOS). Initiation of clinical tracks improves nurse task efficiency, and is adaptable based on any PES patient population. Figure 11.2 depicts tracks, categorized and based on the need for provider time and common problems presented at triage.

The use of clinical tracks was developed to assist nurses in identifying cases that may require increased provider time. These tracks allow nursing staff to assign patients priority for evaluation based on safety and efficiency, and improved efficiency aids in the reduction of overcrowding. For example, the charge nurse may use the clinical tracks to have providers see patients who are likely discharges, which, in turn, reduces volume in the PES. These clinical tracks also allow lead nurses to allocate adequate resources to higher-acuity patients. Figure 11.3 provides an example overview of patient flow based on the triage nurse's assessments with quality improvement (QI) goals.

Training nurses as team leaders to manage patient workflow frees up valuable provider time. Further, the establishment of clinical tracks provides guidelines for initiating nursing tasks such as admission labs, consults, and point-of-care (POC) testing. PES leadership should establish protocols and educate staff using a team approach to ensure quality that is consistent among all staff.

**Fig. 11.2** Triage and clinical tracks





**Fig. 11.3** Overview of nursing triage and patient flow

## 11.4 Quality

The utilization of workflow strategies requires the employment of multiple approaches; therefore, continuous quality improvement (CQI) is necessary to maintain quality nursing care. Lorch and Pollak (2014) describe the steps for CQI as planning, implementation, analysis and comparison of the data collected, and corrective action as needed to meet the established goals [11]. Choosing meaningful and measurable data for collection may vary for different models of the PES but volume or visits, length of stay (LOS), and safety data should be collected on a regular basis to identify problem areas as well as to demonstrate the effectiveness of any project interventions. Additionally, regulatory agency compliance often requires data collection, so nurse leaders should be familiar with requirements that are applicable to the PES.

Because the author's PES model was an emergency room, some of the quality indicators monitored were the rate of patients leaving the PES without being seen (walkouts), patient visit volume, and length of stay (LOS). Nurse leaders should consider areas of improvement for patient safety, as well. Accreditation agencies such as The Joint Commission (TJC) outline focused goals for psychiatric patients that include identification of patients at risk for suicide and patients at risk for falls [12].

Nurse leaders play an important CQI role in PES management. The examples outlined in Fig. 11.4 incorporate quality management data and successful CQI interventions [13]. CQI education should be shared with nurses and all PES team members.

Area of QI data	Intervention	Results
Metrics: LOS>8 h	<ul style="list-style-type: none"> <li>Established Point of Care (POC) testing</li> <li>Clinical tracks</li> </ul>	<ul style="list-style-type: none"> <li>Reduced lab turnaround-time (TAT)</li> <li>LOS was reduced to avg. 6.5 h</li> </ul>
Metrics: Patient walkout rates>9%	<ul style="list-style-type: none"> <li>Nurse lead communication model</li> <li>Quarterly team education meetings</li> <li>Teamwork huddle</li> </ul>	<ul style="list-style-type: none"> <li>Overall walkout rate reduction to &lt;3%</li> </ul>
Safety: Assaults	<ul style="list-style-type: none"> <li>Nurse/staff education</li> <li>Customized triages screenings/risk assessments</li> <li>Standardized nurse policy and procedure</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in patient on staff assaults</li> </ul>

**Fig. 11.4** Overview of achieving success using CQI

## 11.5 Summary

This chapter outlines the importance of the nurse in the PES and describes the functions and roles they serve. Nurses are a valuable resource in PES management, not only as care providers for patients suffering from mental illness, but also as key players in safety and environmental care management. The strategies noted above offer examples in the application of effective management tools and how those management tools contribute to the delivery of safe, efficient, and quality nursing care to patients in the PES.

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# Safety and Security in Emergency Psychiatry

# 12

Victor G. Stiebel

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## Abstract

Every worker, in every workplace, has the right to physical and mental safety. Today's hospital must allow freedom of movement, provide patient care with a minimum of disruptions, safeguard privacy, and at the same time, ensure the safety of all. This balance has become increasingly complex as violence has become more prevalent in society as a whole. This chapter will explore the issues that affect this balance, and propose opportunities for improving safety.

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## 12.1 Introduction

Safety in the health care setting is fraught with ambiguity, which is amplified in the emergency department (ED). The ED is likely to be the most unpredictable department in the hospital as it must offer 24h access to the medically fragile, the psychiatrically ill, and violent individuals, while at the same time ensuring a safe environment. Families may be fearful for their loved ones and confused about the system; and police and security are often present. Mental health patients, although they make up a small percentage of the ED population, may be suicidal or agitated and require a disproportionate amount of staff time. All of this, combined with well-known wait times and inevitable staff shortages, creates a potentially volatile mix. This discussion will be limited to exploring trends in the last 10 years that maximize safety and security for staff and patients.

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## 12.2 Safety as a Common Challenge

In 2015, the Occupational Safety and Health Administration (OSHA) noted that workers in health care settings suffer serious workplace violence at a rate more than four times that of those who work in private industry [1]. This risk actually starts in the field; 80% of emergency medical service (EMS) providers have reported assaults, although fewer than 50% of these sought care or officially reported the incidents [2].

A prospective survey of violence against ED physicians published in 2013 found that 75% reported verbal threats and 28% reported physical assaults [3]. In 2016, Phillips reported that violence committed by a customer or patient of the facility accounted for three-fourth of aggravated assaults, and 93% of all assaults against employees [4]. The immediate impact of violent acts and the longer term effect on emotional and physical health have been well established. Sadly, there is a perception that mentally ill patients are particularly at risk for committing acts of violence; a perception that is heavily influenced by the media. Excluding patients with a history of substance abuse, Choe [5] and Elbogen [6] showed that the mentally ill were more likely to be the victims of violent crimes rather than assailants. In 2010, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) made health care violence a sentinel event [7]. The JCAHO updated the brief in 2019 and noted that the following causal factors contribute the most to violence: leadership, staff, assessment, communication, physical environment, and problems in care planning [7].

---

## 12.3 Leadership Issues

In 1998, Owen [8] described four domains that could predict the risk of violence in an inpatient psychiatric unit: the number of patients, the number with a history of violence, the number of female staff, and the number of staff with minimal



psychiatric training. Much has changed since that study, but many of the basic issues remain.

The ED remains the most difficult administrative area in the hospital for multiple reasons. The vast majority of the mentally ill enter the hospital system through the ED, generating tremendous costs that are hard to recoup. This can limit resource allocation. Patient volume can swing wildly, which has only become worse over the last 10 years. A statistically average number of staff can care for their average number of patients without difficulty, until the number of patients pushes past a second standard deviation point. Patients with a history of violence often arrive in the ED for disposition prior to legal processing. While the number of guns carried by non-military, nonpolice individuals has grown, aggressive screening at entry points may convey a public relation message that is not ideal.

Over the last 10 years, traditionally defined ED staff roles have changed. The number of women entering medical school is now about 50% while the number of men entering traditionally female nursing fields has also increased. This flux in the leadership demographics has often changed the dynamic in EDs, where a work shift with a majority of male nursing staff and a majority of female physicians may be common; although the effect of this change in leadership roles on violent episodes has not been studied. The availability of training for ED staff and security personnel has grown and become more standardized, though it remains a costly endeavor that requires yearly training to be effective [9]. Effective leadership can allocate resources to address these areas; however, even without resources, the Emergency Nurses Association (ENA) surveillance survey [10] showed that EDs with the simple presence of violence reporting policies, and administrations committed to workplace violence control, were less likely to experience violence.

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## 12.4 Staff Issues

ED staffing patterns may not reflect the general hospital environment. A large number of professionals, each with his or her own training and experience, often work together on an ad hoc basis. Critical care staffing shortfalls in the department are more easily covered using outside agencies, but these staff may have limited and inconsistent experience when dealing with mental illness. Additionally, transient staff may not be familiar with hospital nuances. In teaching centers, students and residents fill critical staff needs and they are likely to be the first to see a new patient; however, trainees often lack formal training and experience with acutely ill psychiatric patients. A nurse in a triage or reception area will often meet an unknown patient for the first time, alone, usually in the setting of a relatively isolated triage or examination room. Full-time psychiatric staff is rare in EDs, although the expanding use of telepsychiatry can provide a partial solution to the deficit.

---

## 12.5 Resident Issues

Lacking experience, a resident may miss subtle, but important, aspects of the history or physical exam. When faced with a difficult, agitated, or intoxicated patient, countertransference issues such as anger toward the patient, or feelings of helplessness, can develop. Errors may occur through inappropriate orders, nuanced speech patterns that are picked up on by patients, or a simple lack of awareness of interpersonal space issues.

Other factors common to residents include the ubiquitous lack of sleep, service obligations requiring ED coverage, and a reluctance to approach staff with clinical concerns. In 2011, Behnam [11] found that residents early in training were more likely to be verbally threatened, but senior residents were more likely to be physically assaulted; this fact suggests that a patient's initial anger may be directed at a trainee encountered early in the ED process. A more experienced resident may not get involved until a patient becomes more agitated, or has been in the ED process for an extended period of time. Interestingly, attending staff reported assaults much less frequently, which suggests that experience makes a difference.

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## 12.6 Nursing Issues

In their National Crime Victimization Survey [12], the United States Department of Justice noted that violence against nurses accounted for 4% of workplace violence. The only individuals more likely to suffer violence were members of law enforcement. The 2011 Nursing Survey showed that violence has not diminished in the last 10 years [10]. In the week prior to the study, more than 50% of nurses had experienced verbal abuse and 12% had experienced physical violence. Over 80% of these episodes occurred in patient rooms. Nurses are closely involved when restraining patients and are therefore more likely to be injured. While they provide medication for pain relief, nurses are also the ones who may be responsible for painful procedures. Nurses, often pulled from other units or staffed from outside agencies, may not be as familiar with the nuances of the specific ED, or have experience with mental health patients. Experience is, again, a critical factor, with more episodes of violence reported by younger nurses serving in staff nurse roles [10].

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## 12.7 Patient Issues

Individuals with unrecognized risk factors often pose the greatest risk to staff. For instance, visitors are often the perpetrators of violent acts against staff, or bring in contraband. Nevertheless, an agitated, medically ill, altered mental status patient still has a significant likelihood of causing harm, even with appropriate safety precautions.

Certain psychiatric diagnoses can also alert staff to the potential for acting out. Antisocial personality disorder may present with violence directed toward others,

while a patient with borderline features may be more at risk for self-injury. A diagnosis of schizophrenia or bipolar disorder could alert staff to underlying command hallucinations or manic impulsivity; however, psychiatric illness in and of itself does not account for most of the violence in society [13, 14]. Violent mentally ill patients are more likely to harm themselves rather than someone else. These cases of interpersonal violence make up less than 5% of violent acts [13].

This lower risk does not hold for mentally ill patients who are substance abusers. Intoxication, a significant risk factor, appears to have worsened in the last decade. A 2013 British National Health Service survey found that about 30% of violent incidents were intoxication related [15]. A history of any substance abuse, even if the patient is not actively intoxicated, increases the risk of violence. Traditional sympathomimetics, such as cocaine, have now given way to methamphetamine and other central nervous system (CNS) stimulants. Abused substances may include intentional overdoses of over-the-counter medications, such as dextromethorphan, in order to produce intoxication. Opioids now encompass far more toxic synthetics, such as sufentanil, which may not be detected by traditional drug screens. Patients presenting from jails or similar detention settings should have priority drug screening, as these patients account for 29% of shootings in EDs, with 11% of these occurring during an escape attempt [16]. Some individuals from forensic facilities may be intoxicated or withdrawing. Gang membership often provides access to guns or weapons, and the related culture may normalize violent behaviors. Youths are more at risk for violent acting out due to multiple factors including immaturity, lack of socialization, and greater strength [4, 13, 15].

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## 12.8 Violence Assessment

Violence is a clinical state, not a mental health diagnosis. The violent act can be physical, verbal, or sexual, and the perpetrator can be young or old. Violence can occur in any setting, including the criminal justice system, inpatient or outpatient mental health settings, or simply on the street. Violence can be drug related, and can occur in rural or urban settings.

Risk assessment in previous generations was used simply to attempt to predict risk following a prolonged inpatient hospitalization for the most impaired individuals who were well known to their providers. Community based mental health centers now bear the brunt of the burden of care for these extremely ill patients, usually without the benefit of long-term contact. Efforts to find guidelines to assess and predict violence have had limited success because the result of any tool is only as good as the historical information that it is used to analyze. Finding the ideal assessment tool to assess risk, or more specifically, to predict violence, has been a challenge. As a result, no one instrument can be used in every clinical setting, including in the ED. Despite this uncertainty, various tools have been increasingly used to make risk assessment decisions for inpatient utilization review, civil and criminal court outcomes, and level of care determinations.

One of the main problems is that if a risk of violence is high, there is a moral and ethical obligation to intervene, regardless of what a test might conclude. In medication trials, one can look at the number needed to treat for efficacy. When assessing violence, one needs to think about the number needed to detain (NND). If one could determine a baseline of violence of 10%, then ten people would need to be detained to prevent one violent act. However, as the base rate declines, the number needed to detain would rise. The National Institute of Mental Health Epidemiologic Catchment Area (NIMH ECA) study using a baseline violent act rate of 17% would result in the NND of 3.5 people [17]. The National Institute of Mental Health Clinical Antipsychotic Trials of Intervention Effectiveness (NIMH CATIE) project found that the prevalence of assault was 3.6% [18], so the NND would rise to 15, at the same levels of sensitivity and specificity. This has significant ethical ramifications for clinicians who must balance the competing clinical interests of patient autonomy with the safety of others [19].

Singh [20] reviewed 68 studies to determine which ones had the highest rates of predictive accuracy. The authors reviewed over 120 different risk assessment tools validated across a range of inpatient and outpatient clinical settings, civil and criminal court systems, in the United States and abroad. The study concluded that there were substantial differences between instruments and that their accuracy improved if they were used on the validated population; the best predictive rates were for older, predominantly white populations, a population that may not accurately reflect clinical reality. A resource document on psychiatric risk assessment by the American Psychiatric Association in 2012 also reviewed various instruments, and found that structured approaches to risk assessment performed better than unstructured [19]. The group noted that the overall accuracy of prediction tools increased from 1970 to 2000; however, in the end, clinical judgment is key to the interpretation of a test result, and an understanding of multiple risk factors is paramount.

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## 12.9 Communication

The concept of the “patient hand-off” and concerns about information being lost during a change of shift is an old issue that has gained even more attention recently. Clear communication between team members is one of the biggest risk mitigation factors, especially in the ED setting. Conversely, poor communication can lead to disastrous outcomes. In 2017, a Joint Commission Sentinel Event Advisory [21] emphasized that communication failures and deficiencies were responsible for many of the 60% human-related factors in ED violent acts. Communication failures accounted for 30% of malpractice claims in 2015 [21].

The sequence of events may start in the field when police or emergency medical services receive a call reporting agitation or violence. These personnel often gather important information about the location where the patient is found, whether there is evidence of drugs or alcohol at the scene, and other collateral information. Unfortunately, the police may be absent when the patient arrives and medics, if not asked, may only leave basic information. Hospital security may be present but not

briefed about their role in the crisis. Nursing staff may be reluctant to call for help due to concerns about perceived weakness, or there may simply be a lack of backup staff. Residents may not want to share their lack of knowledge and only call staff physicians after a situation develops.

Despite all of these issues, good communication is certainly possible, and has been discussed very recently [22–24]. When the team is well organized, information will flow seamlessly from the field, to security, and to the nurses and physicians. The use of a standard “handoff template” can ensure the transmission of consistent data, limit duplication, and enhance timeliness; these templates are now often the standard of care. Even more recently, an electronic format hand-off has gained traction. Though hand-off is traditionally a nurse-centered task, in some circumstances, the patient can actually be an active participant in the process [24]. Whichever format is used, verbal or checklist, adherence to these concepts will clearly improve the quality of care, increase staff-patient satisfaction, and facilitate safety for everyone.

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## 12.10 Physical Environment

A complex interaction of factors in the physical plant come together in the ED to create an ideal setting in which violent acts can occur. Identifying these factors allows for interventions and unique solutions. A review done in 2016 summarized some specific environmental conditions associated with violence that are particularly germane to the ED: high acuity, crowded areas, noise, and the presence of substitute personnel [25]. Additional factors include long wait times, lack of information passed to patients and families, and the presence of loud or agitated patients or visitors [26]. While it is important to be aware of these issues, none is easily resolved in our current crowded medical system; therefore, awareness remains key to risk mitigation.

Multiple ingress and egress points facilitate patient movement and can promote a community feel to the department; however, these factors can also make it very difficult to monitor patients and visitors. Metal detectors, security cameras, and an increased security presence can be effective. Multiple controlled access doors can facilitate staff movement and patient flow, but limited access for visitors is usually required. Disposable colored wristbands or colored gowns can provide varying degrees of information and can further facilitate identification; however, the legality of requiring all mental health patients to change into gowns was successfully challenged in 2009 [27]. The ENA study [10] found that the greatest risk of violence was in patient rooms, corridors, halls, stairwells, and elevators. Due to privacy issues, patient rooms may lack recourse other than alarm systems or “panic buttons” worn by staff. Areas should be well lit, and minimize blind spots or hiding places.

Though security cameras can further assist in monitoring less accessible areas, they can also lead to a false sense of security. Camera monitors can induce a low level of stupor in the personnel assigned to watch them, and the attention span of an individual monitoring them begins to fail after just 20 min [28]. The more monitors watched correlates with decreased accuracy of detection. A security officer

watching one monitor for up to 2 h can maintain an accuracy level of 85%, but this drops to 53% with nine monitors [28]. Despite these limitations, video monitoring is likely to remain a part of a comprehensive security plan.

Metal detectors, whether hand held or walk-through, can elicit strong arguments, both pro and con. Their goal is to prevent entry of weapons into the hospital; however, the use of metal detectors sends a potential political statement to the community that hospitals may not desire. In addition, metal detectors may not reduce violent acts in the ED setting and require continuous security personnel, a significant budgetary consideration. One older study showed that while the number of weapons confiscated increased, the use of metal detectors did not lead to a decrease in violent episodes [29]. The most recent study from 2003 found that metal detectors resulted in 3446 weapons confiscated in a 1-year period, but almost 80% were knives or other cutting tools; only 0.1% were firearms. Also noteworthy was that 41% of weapons were confiscated from patients who had bypassed security because they arrived by ambulance [30].

Security personnel have become ubiquitous. They come from many backgrounds and assume many roles, some armed with guns, some with Taser type devices, and some with a simple uniform. Training backgrounds can vary widely and may not mesh with the hospital environment. Few have had formal training with mental health patients and the unique aspects associated with seclusion and restraint. The presence of security officers, however, does seem to be associated with decreased violent episodes [31]. A 2014 survey showed that the number of hospital security personnel carrying handguns and Tasers doubled between 2010 and 2014 [31]. Fisher [25] reported that as of 2016, 52% of hospitals had personnel with guns and 47% with Tasers. Furthermore, facilities that allowed security personnel to carry Tasers had a 41% lower risk of physical assault, even when controlled for other factors [31]. An unanswered question is whether it is the presence of security personnel, or the fact they are carrying weapons, that lowers aggressive acts.

Unfortunately, weapons can present a mixed risk-benefit. In the last 10 years, incidents have been reported of patients killed or injured by hospital security personnel [32]. The National Crime Victimization Survey reported that between 2000 and 2011, there were 154 shootings at American hospitals, with 41% occurring on the general hospital campus and 29% in the ED. It is noteworthy that in 20% of the cases, the perpetrators did not bring their own firearms, and in 8% of the cases, the gun was taken from the police or security officer on the scene [33].

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## 12.11 Summary

Every worker, in every workplace, has the right to physical and mental safety. In the emergency department, this right extends to our “customers,” their families, and visitors. While there has been much positive movement in this broad area of safety in the last 10 years, medical staff, especially nurses, continue to lead national statistics in physical injuries and disability. The ED team begins with prehospital personnel, police, and emergency medical services (EMS); and extends to the inpatient

units. There is still no ideal solution, and every ED and community will need to find a balance. Safety begins with strong, involved leadership, solid communication throughout the team, ongoing training, and continuous risk mitigation strategies that are literature based and broadly implemented.

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# Supervision of Ancillary Personnel

# 13

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## Abstract

Increasing numbers of patients seeking emergency psychiatric care have caused a staffing crisis in emergency departments with insufficient mental health pre-prescribers available to manage this increased volume. This chapter will outline best practices for nonprescribers to work effectively in the emergency psychia-

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try setting, and will highlight the benefits of including students and residents as part of the workforce in an institution's response to the growing need for psychiatric emergency care.

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## 13.1 Introduction

The increased volume of patients seeking psychiatric care in emergency departments (EDs) has caused a staffing crisis that requires innovative solutions to decrease the strain on these already overwhelmed and crowded services [1]. There are also insufficient mental health prescribers to manage the increasing number of behavioral health presentations to EDs [2]. Strategies to effectively utilize other mental health professionals and trainees (residents and students) are one common solution to this problem. This chapter will outline best practices for nonprescribers to effectively work in the emergency psychiatry setting, and will highlight the benefits of including students and residents as part of the workforce in an institution's response to the growing need for psychiatric emergency care.

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## 13.2 The Rationale for Psychiatric Emergency Clinicians (PECs)

Licensed, experienced, nonphysician mental health clinicians can be utilized to serve in the role of psychiatric emergency clinicians (PECs). These professionals (clinical social workers, clinical psychologists, and licensed mental health counselors) already have extensive training in the evaluation and treatment of psychiatric disorders. While they do require additional emergency psychiatry training, these professionals can safely and effectively be trained to manage psychiatric emergencies. In a previous paper [3], the authors proposed the need for a skill set that includes the ability to perform a rapid biopsychosocial assessment, including a psychiatric and medical review of systems; a mental status examination; and a risk assessment. Once an evaluation is complete, the PEC must develop a differential diagnosis and formulation, as well as a sound treatment plan and disposition. These clinicians are able to evaluate patients for admission to psychiatric units, manage involuntary holds and are skilled in conducting patient interviews and verbal de-escalation (see the summary of skills outlined in Table 13.1). These clinicians have the unique ability to develop a therapeutic alliance and provide crisis intervention, through the utilization of their distinct training in mental health assessment and treatment.

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## 13.3 Essential Skills for PECs

A knowledge base which is different from that of the traditional psychotherapist is essential for PEC competency. This knowledge base includes basic medical knowledge, the ability to comfortably read and understand the medical record, recognition

**Table 13.1** Clinical skills for PECs

• Rapidly establish rapport/build an alliance
• Determine the “chief complaint” and “request” [4]
• Possess advanced interviewing skills
• Knowledge of verbal de-escalation
• Knowledge of crisis intervention skills
• Perform independent evaluations of behavioral health conditions with a focus on triage, stabilization, and safety assessments
• Obtain collateral information
• Liaison with community including outside providers and clinics, police and emergency medical services, and families
• Collaborate with emergency setting clinical teams across disciplines and specialties
• Possess self-awareness and recognition of clinician–patient dynamics that may complicate medical and psychiatric examination
• Assist in the recognition of medical illnesses, states of intoxication and withdrawal, and adverse drug reactions presenting with behavioral health emergencies
• Assist in the management of behavioral emergencies (determination of potential need for medications and subsequent impact of such treatment, potential need for restraints vs. reducing the need for restraint)
• Arrive at differential diagnosis and biopsychosocial formulation
• Utilize clinical decision-making skills based on available data
• Develop appropriate treatment plans, including but not limited to, disposition planning
• Ability to document in the medical record, including the rationale for releasing patients who may have some risk factors or necessity for hospitalization
• Recognize circumstances where specialized consultation from a psychiatrist or emergency physician is indicated
• Demonstrate knowledge of medicolegal issues such as involuntary holds and decision-making capacity

**Table 13.2** Basic medical knowledge

Knowledge of how to read and understand the medical record
The meaning of vital signs (normal and abnormal)
The definition of, and how to perform a medical review of systems
Common medical conditions
Psychopharmacology—indications, side effects, adverse reactions

of medical illness, and understanding the meaning of common laboratory values and physical findings (see Table 13.2). In addition, a PEC must have working knowledge of behavioral manifestations of medical conditions such as toxidromes, endocrine, and neurological conditions; as well as knowledge of basic pharmacology, adverse reactions, and side effect profiles, as summarized in Table 13.3.

Training can be conducted through on-the-job apprenticeship supplemented with didactic learning. Recommendations for training are based on a model curriculum written for psychiatric residents training in emergency psychiatry [5]. A recent literature review on the topic of nonphysician mental health providers in the emergency setting produced a few relevant publications. Although these references were

**Table 13.3** Medical conditions presenting as behavioral emergencies

Endocrine disorders
Common neurological disorders
Toxidromes
Delirium
Substance abuse-intoxication/withdrawal states
Pain
Adverse reactions to medication

quite old [6–11], they did have their own curriculum models that have been drawn upon for this chapter.

While such training can be initially time intensive, the result can be quite effective and ultimately, reduce overall costs. The best way for such training to occur is twofold: formal didactic presentations of the topics outlined in the tables, and (more importantly), an apprenticeship working with seasoned providers. The clinician initially sits in with faculty and senior clinicians, watching their interviews, and reviewing each case carefully with the senior clinician. The senior clinicians should include a variety of professionals, including other experienced PECs, emergency physicians comfortable with psychiatric cases, and psychiatrists. Incrementally, the PEC then conducts the interview with faculty in the room to allow for in situ teaching. The new PEC then reviews the pertinent findings with the faculty, including decision-making rationale. The PEC’s documentation is reviewed during and/or after each case.

The PEC then moves on to conduct evaluations independently, and reviews each case with the supervising clinician. During this process, the PEC learns what elements of the exam may be missing. They can go back and ask the patient about pertinent information that the supervisor finds necessary. Practice in case presentation and noting any missing information allows the PEC to evaluate for themselves what they have mastered, as well as what still needs to be incorporated into their skill set to enable them to reach full competency. This in situ training is expected to last 3–6 months.

### 13.4 Clinical Example

This clinical example illustrates how a PEC can provide a unique, and timely assessment of a patient with a behavioral health emergency.

A 43-year-old married man with a history of combat-related post-traumatic stress disorder and traumatic brain injury was referred to the ED by his therapist when he revealed to her that he had been thinking about killing himself for several weeks. The therapist contacted the PEC and provided collateral information before the arrival of the patient. Despite his considerable distress, the patient had continued to function well at work and home, raising two children with his wife

of 17 years. He had been on sertraline without relief and had cross-tapered to citalopram one week earlier. The patient had a strong relationship with his therapist and had no history of drug or alcohol abuse. Within the past 8 months, two combat buddies had killed themselves. He owned a firearm but reported that it was in a locked safe and that he had no ammunition in his home. Most concerning was his statement that he thought that his children would be “better-off” without him.

During the emergency evaluation, the PEC suggested to the patient that killing himself might not necessarily help his family in the ways that he thought, but would traumatize them analogous to how he had been traumatized. This idea caught the patient’s attention and helped him reframe his situation. The thought of his children suffering arrested the obsessive thinking about killing himself. He also noted that he had seen how the families of his deceased buddies had suffered after their deaths.

Despite his worrisome risk factors, the PEC did not recommend hospitalization because of the patient’s strong connection to his therapist, and his ability to rethink his perception of how life would be for his family after a suicide death. After calling his wife, who was supportive (and who verified the location of the firearm and lack of ammunition), and making arrangements for him to see his therapist the following day, the PEC made the determination that the patient was able to be safely discharged.

The PEC also contacted the patient’s outpatient psychiatrist to discuss her thoughts. The psychiatrist agreed with the PEC’s assessment, and felt that continued outpatient care was appropriate. The psychiatrist reported that she had been considering an increase in citalopram, and agreed to call it in to the pharmacy earlier than at the planned follow-up.

Follow-up indicated that the patient had sustained relief from suicidal ruminations and continued to do well after his interaction with the PEC. He reported to his therapist that the PEC was very helpful to him, and both he and his therapist felt the emergency department visit was a positive turning point in his care, one which had obviated the need for hospitalization.

This vignette illustrates how an assessment of risk requires training, interpersonal and therapeutic skills, resource utilization (both professional and social), and the ability to accept a heightened level of risk. The PEC was able to conduct the evaluation thoroughly with all of the collateral information that had been received. She had the time to not only hear, but to also incorporate the therapist’s information into the evaluation, and had the time and foresight to call the patient’s psychiatrist. Even if a physician was performing the psychiatric assessment in the ED, it is unlikely that changes in psychiatric medication would be made in this setting, and the patient would have been referred back to the prescriber for medication adjustments. While any psychiatric provider seeing this patient would have been sure that someone spoke to the patient’s wife, the PEC made the call herself. In doing so, further diagnostic data could be obtained and integrated into the treatment plan. This was the case for the follow-up as well, which was also conducted by the PEC.

### 13.5 Psychiatric Trainees (Residents/Students) as PECs

Trainees, both residents and students, can also help decrease the strain on EDs that are facing a large and increasing number of psychiatric patients. While learners need supervision and guidance, they can assist with some of the work such as documentation, calls to insurance companies for authorization, and calls to outside facilities for patient placement [2]. They can also assist with moment-to-moment assessment and management, so that a physician or another senior mental health clinician can oversee more cases at a given time. Furthermore, their presence might make the work of a busy service more enjoyable for the regular provider staff [12].

An emergency psychiatry experience offers many educational advantages. In addition to learning differential diagnosis, risk assessment, emergency care management and disposition, and the experience of exposure to the chronically mentally ill, legal aspects of patient care such as the capacity to make decisions, commitment laws and mental health codes, are curricular areas that can be covered. Seeing patients with anxiety, depression, and psychosis from first presentation; experiencing the power of crisis intervention whether the patient is dealing with a medical or a psychological crisis; learning firsthand about limited resources in the community; and knowing how to best help an underserved population are vital lessons that an emergency psychiatric experience will inevitably include.

The inclusion of psychiatric residents in the assessment of patients with psychiatric complaints in the ED is common, and a number of authors have written about how best to do this. A Model Curriculum developed by the American Association for Emergency Psychiatry was published in 2004 [5] which includes recommended training objectives, didactic topics, and supervisory oversight. In addition, emergency psychiatric exposure provides an invaluable educational experience for psychiatry residents. Understanding the whole patient experience, from emergency presentation through outpatient follow-up, and learning emergency therapeutic techniques from verbal de-escalation to medication management, enhances and solidifies psychiatric skills. Psychiatry residents might work in all models discussed in this textbook; therefore, the residency training director must ensure that the experience satisfies curricular requirements, includes adequate faculty oversight, and has educational merit.

Emergency physicians and administrators who design psychiatric emergency services should consider including emergency medicine (EM) residents in a manner that allows them to get additional, specialized training in handling psychiatric emergencies. While Accreditation Council for Graduate Medical Education (ACGME) requirements for psychiatry training in emergency medicine residency are sparse, the presence and growing numbers of patients presenting with psychiatric complaints justifies some curricular time in this area. Assigning an EM resident to work with the mental health team, even if just for a short time, would provide more direct training in assessing depression, psychosis, anxiety, and suicidal thoughts or behaviors. The EM resident can learn more about when hospitalization is required in a psychiatric emergency, and what alternatives to hospitalization exist locally. They

could come away from this experience with important knowledge and skills which they may have no other way of obtaining. Medical students, nursing students, psychology interns, and social work students can also gain important knowledge and skills in a psychiatric emergency service setting. Pairing each student with a seasoned clinician in their field for an observation experience is the first step, but depending on the length of time the student spends in the emergency psychiatry setting, graded, increased responsibilities can be added, and these students can also assist with patient care in limited ways.

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## 13.6 Summary

This chapter addresses an effective way to use nonpsychiatrists as part of the workforce that assesses and manages psychiatric patients in EDs. This chapter outlines a model to train and utilize nonprescribing mental health professionals to serve as the psychiatric presence in the ED when there are no residents and/or no other psychiatric staff available. With proper education and experience, these PECs can competently care for patients in EDs independently or with minimal supervision. The authors also briefly discuss trainee involvement in the care of psychiatric patients since residents and students can assist with management of this workload, but they do require a higher level of supervision than a well-trained and seasoned PEC requires. Telepsychiatry can be used as a part of the training process for PECs if face-to-face training is not feasible. The guidelines discussed in this chapter should assist EDs in their decision-making process around hiring individuals as they seek to meet expanding needs for emergency psychiatric services.

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# Financial Considerations for Emergency Psychiatry Services

# 14

Neil A. Gray and Junji Takeshita

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## Abstract

Funding for psychiatric emergency services (PES) presents a serious challenge to hospitals due to a combination of low reimbursement rates, high infrastructure costs, and accompanying psychosocial complexity including poverty, homelessness, and substance use. This chapter reviews some financial models of care delivery and suggests a method of analyzing systematically the financial viability of starting a psychiatric emergency service.

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## 14.1 Introduction

Health care in the United States is expensive, and psychiatric services are no exception. Psychiatric emergency services (PES) have the potential to provide an important service in communities across the country, improving health care and minimizing unnecessary burdens upon families and communities. Unfortunately, the implementation of PES within hospital settings is often seen as an unattractive prospect as the costs associated with running such a facility outweigh the direct revenue of such an endeavor. However, these calculations are often based on an oversimplified view and commonly minimize the more broad reduction of indirect costs. In this chapter, the authors will outline the scope of the impact of successful PES implementation, illustrate examples of successful models tailored to individual communities, and outline how one might construct an appealing “pitch” for introduction of similar practices.

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## 14.2 Financing Psychiatric Emergency Service: The Intersection of Psychiatry and the Emergency Room

Health care accounts for a substantial proportion of the gross domestic product (GDP) in developed countries. This is especially true in the United States, where in 2016, health care spending amounted to 3.3 trillion dollars, representing 17.9% of the gross domestic product [1]. The emergency room (ER) of a general hospital is the typical first entry point for psychiatric treatment, especially involuntary treatment.

In general, psychiatric care, like all medical care, is funded by numerous sources. The largest portion is covered by the government. Himmelstein and Woolhandler estimated that in 2013, government (tax-funded) health care costs accounted for 64.3% of total health care expenditures [2]. Private health insurance also contributes a substantial proportion of health care revenue. Further income is driven by out-of-pocket costs borne by the patient.

Medicare is the government insurer of the elderly and severely disabled; Medicaid covers very low-income children and adults and is often contracted to private insurance companies to manage. Unfortunately, Medicare and Medicaid reimbursement rates are often below the market costs of psychiatric care. This is especially impactful in emergency psychiatric care settings where a large proportion of the patients carry government insurance, and these patients often require a higher frequency and intensity of services than commercially insured patients. As a result, in the absence of funding from additional sources, PES are not financially viable. Not surprisingly, the patient is not a reliable source of funding. Many PES patients are indigent, homeless, or uninsured, and billing the “self pay” patient rarely results in collection of funds. The current opioid crisis (as well as other substance abuse) compounds the need for PES. As this population ages, already limited PES resources are expected to be further strained, and services for the elderly have largely been ignored to date [3].

Historically, most psychiatrists provide care in the outpatient setting with greater emphasis on psychopharmacology rather than psychotherapy. Compared with other specialties, psychiatrists are much less likely to accept any form of insurance: 55.3% of psychiatrists accept insurance versus 88.7% for other specialties, and 43.1% accept Medicaid versus 73.0% for other specialties [4]. Moreover, high risk patients are routinely referred to the emergency room due to fears of liability, lack of time and expertise, and the fact that emergency rooms are unable to refuse these patients due to the Emergency Medical Treatment and Labor Act (EMTALA), which stipulates that all patients must be seen and stabilized regardless of ability to pay. Thus, the highest-risk patients, who tend to be the least well-insured, are funneled into the emergency room when psychiatric crises occur.

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### **14.3 The Hidden Costs of Not Having Psychiatric Emergency Services**

Many hospitals have decreased the number of inpatient psychiatric beds due to problems with reimbursement and a growing focus on expanding care in the community. Public psychiatric beds have gone from 340 per 100,000 in 1955 to 17 per 100,000 in 2005 [5], and inpatient hospital beds in the private sector have not increased. The decreasing number of inpatient psychiatric beds has substantially increased the number of patients boarding in the emergency room, awaiting transfer to a psychiatric facility.

In parallel, public sector outpatient resources have not provided adequate care to fill this void. Nickes and Manthey [6] note that boarding costs the emergency department an average of \$2264 per patient, including \$1198 in direct loss, with the remainder of the cost being attributed to the opportunity cost of due to the bed being occupied. An American College of Emergency Physician's survey found that doctors reported boarding over 4 h occurred in 60% of emergency rooms across the United States during their last shift, in some cases for over 24 h [7]. Likewise, a survey of emergency physicians reported that 70% had psychiatric patients boarding during their last shift [8]. Therefore, psychiatric emergency services may not be a financially attractive prospect for the hospital, but are nonetheless necessary for efficient administration as they are vital to minimizing potential losses associated with opportunity costs.

In addition to savings driven by reductions in psychiatric boarding, PES also provide other streams of indirect revenue and cost reduction. Psychiatric patients in ERs that do not have PES represent a significant liability. Psychiatric patients are a common source of EMTALA violations due to inadequate treatment or stabilization [9]. These violations may result in fines, lawsuits by patients or receiving hospitals, and, in extreme cases, termination of Medicare Provider Agreements. Likewise, having general ER staff handle psychiatric patients, particularly when boarding is a problem, can lead to lower morale, increasing burnout, and staff turnover.

However, the inclusion of psychiatric staff in emergency settings is clearly associated with greater financial burden. Patient billing revenue is highly unlikely to

cover the average salary of a psychiatrist; low rates of reimbursement from insurers, further exacerbated by high numbers of uninsured patients, will not be sufficient to pay for adequate compensation (though care provided to the uninsured may be reimbursed by county or state governments in some areas). However, tabulating numbers of patients allows a measure of productivity (e.g., reduction in boarding, decrease in unnecessary admissions). Quality measures such as readmission rates, length of stay in the ER, and other factors which may influence the quality of care, and thus reimbursement for the hospital, may be improved through psychiatric intervention.

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#### **14.4 The Direct Costs of Running a Psychiatric Emergency Service**

The volume of psychiatric services provided is typically driven by patient numbers. Clinical work output is determined using work relative value units (wRVUs), and billing codes include the psychiatric code (90792) or evaluation and management codes (99 series). The latter is further stratified using emergency room codes versus general hospital codes. The cost of providers, including psychiatric nurses, advanced practice nurses (APRN), psychiatric social workers, psychologists, and psychiatrists, plays a key role in determining staffing of the psychiatric emergency room. For example, APRN reimbursement is typically at 85% of the physician rate for Medicare, but this reduced reimbursement may be more than offset by reduced cost. Coverage via telepsychiatry may be another option for low volume emergency rooms which cannot justify a dedicated in-house mental health professional.

Thus, determining the financial viability of operating a PES in-house involves ascertaining whether the sum of patient billing, physician collections, community funding, and improved efficiency/throughput of other insured patients is greater than the cost of the psychiatric infrastructure and personnel. In calculating the finances for a typical emergency room, a “pitch” to a hospital administrator solely involving wRVU and billing collection will woefully underestimate the potential benefit of a PES. Tables 14.1 and 14.2 illustrate some ways to think about “selling” a psychiatric emergency service, and Table 14.3 highlights one possible scenario.

As an example, the average wRVU associated with a new patient (3.25 wRVU) translates to about \$128 [10]. Assuming an average of one patient per hour, and an average psychiatrist rate of \$150/h, then a subsidy is required just to cover the cost of the physician. This does not include further costs associated with running the emergency service, such as other ancillary nursing personnel, housekeeping, and security.

However, while actual billing will fund only a fraction of a PES, multiple other indirect savings may render it cost-effective, including greater ER efficiency, reduced boarding, improved patient satisfaction, improved hospital efficiency, and decreased hospital liability. For example, without a formal PES to “clear” a patient, an ER physician is left with unsatisfactory choices: risk a potentially unsafe discharge, or transfer to a psychiatric facility that may be unnecessary and may lead to prolonged boarding if beds are not immediately available. Discharge of such a

**Table 14.1** Psychiatric emergency service model based on patient volume

Patient volume	Frequency of boarding	Suggested model of emergency psychiatric care
Very low	Rare	Telepsychiatry or Transfer to facility with psychiatry coverage
Low	Occasional	Telepsychiatry and/or Daytime psychiatry coverage
Medium	Common	24-h psychiatry coverage or Telepsychiatry
High	Frequent	Dedicated emergency psychiatric facilities (CPEP model)

*CPEP* comprehensive psychiatric emergency model

**Table 14.2** Financial benefits of psychiatric emergency services

Direct revenue	Amount	Indirect savings/intangibles	Benefit
Billing	Low-moderate	Reduction of boarding	High
Hospital subsidization	Moderate	Reduction of potential EMTALA violations/liability	High
Government funding (city, county, state) Value-based incentives	High	Public relations and staff morale	Moderate
		Patient satisfaction	Moderate-high

Summary of direct and indirect cost savings that psychiatric emergency services may accrue  
*EMTALA* Emergency Medical Treatment and Labor Act

**Table 14.3** Sample balance sheet for evaluation of options for psychiatric emergency services

	Case #1: “Business as usual”	Case #2: Hourly psychiatrist	Case #3: Telepsychiatry
Average 8 daily patients with psychiatric complaints	4 patients admitted by ER physician	3 patients admitted by ER psychiatrist	3 patients admitted by telepsychiatrist
Boarding	2 patients (\$4528)	1 patient (\$2264)	1 patient (\$2264)
Psychiatric interview (90792)	\$0	8 × \$128 = \$1024	8 × \$128 = \$1024
Psychiatrist cost	\$0	\$150/h × 24 h = (\$3600)	\$500 daily + \$200/pt = (\$2100)
Net earnings/(cost)	(\$4528)	(\$4840)	(\$3340)

This table assumes a hospital with no in-house psychiatry service, where all patients are seen, and their disposition determined, by an Emergency Medicine physician. On average, eight psychiatric patients present daily, and the emergency medicine (EM) physician refers half for inpatient admission. A psychiatrist will likely be able to discharge a higher proportion, thereby reducing the number admitted (and therefore reducing boarding). This table does not tabulate other potential benefits, such as follow-up billing of boarders, decreased time to follow-up for boarders, improved patient satisfaction, and decrease in physician frustration

patient has significant EMTALA and malpractice concerns, especially if the documentation supports instability.

The Affordable Care Act (ACA) introduced a number of incentives and penalties meant to improve the quality and efficiency of care, which may increase the indirect savings from a PES and thus make it more attractive to hospital administrators. Currier notes that the ACA has called for elimination of the Disproportionate Share payments which provided hospitals with funds to help care for indigent patients as more patients would be insured under the act [11]. Such national changes in health care finance affect all aspects of patient care delivery. The ACA is currently undergoing even further modifications which will undoubtedly influence the organization of a PES.

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## 14.5 Selecting an Appropriate Model of Psychiatric Emergency Services

Depending on the level of unmet need for the hospital and, more broadly, the community, the merits of the various models of PES discussed in earlier chapters can be weighed. As suggested by Barton [12], a good first step is to develop three distinct budgets: (1) statistical—the amount of demand, the services to be offered, and the targeted and untargeted populations; (2) expense—the salaries, benefits, and operating expenses; and (3) income—insurer reimbursements, local and state agencies, justice system, with the deficit an acceptable subsidization by the hospital. This can be further expanded by cataloging the indirect costs accrued in the absence of a PES (as described previously).

For a hospital or hospital system with an existing inpatient psychiatric unit, adding a PES may be an attractive prospect. Without a PES, the unit is reliant upon transfers from outside facilities and direct admissions, and may thus frequently have unfilled beds. The addition of a PES would allow for patient admissions to the affiliated unit to be prioritized, maintaining the operation of the unit closer to capacity. Additionally, this arrangement improves transition of care and reduces instances where a patient arrives not as described to the accepting unit, thus improving morale. Finally, bundled payments for admitted patients may not appear directly as PES revenue, but contribute to the hospital's overall revenue.

Physician staffing for PES can take a variety of forms. Small hospitals may have sufficient volume to justify a staff psychiatrist who consults on both inpatients and in the ER. Contracting with a telepsychiatry firm may also be desirable, either for night/weekend coverage for hospitals/ERs with a staff psychiatrist, or for all coverage in cases of very low volume. Others may find hiring psychiatrists at an hourly rate (typically as a side job) a preferable alternative depending on the local availability and market. For teaching hospitals, resident coverage with attending supervision is the norm. In high volume ERs, there is typically a need for both full-time/salaried and hourly psychiatrists. In order to attract and retain dedicated staff, various incentive structures may be considered, with attention being given to the inherent variability of volume in the emergency setting. The use of APRNs is also a

consideration (reducing both cost and reimbursement), but will depend on the laws of the state. In all settings, availability of social workers (particularly those with mental health experience) will improve psychiatrist efficiency by taking on necessary tasks such as calling for collateral history, coordinating hospital admissions, and arranging safe discharges (e.g., outpatient follow-up, crisis housing).

In the United States, the specific approach to designing a PES is also dependent upon state and local laws and regulations. For example, New York allows for the designation of Comprehensive Psychiatric Emergency Program (CPEP). Requirements for staffing, affiliated services, and the physical plant for a CPEP are significant: 24-h physician staffing, a social worker present for 10 h per day, an affiliated mobile crisis team, extended observation beds in individual rooms, and shower and dining facilities must be available. The incentives of a CPEP for the hospital include approximately doubled reimbursement rates for “treat-and-release” patients and billing at full inpatient rates for patients placed in extended observation beds [13]. The initial investment plus ongoing staff costs are discouraging, but for facilities with large enough patient throughput these are offset by potential revenue and may even achieve a balanced budget based solely on insurer reimbursement.

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## 14.6 Outside Funding and Community-Wide Collaboration

The addition of a new PES to a community has the potential to significantly benefit multiple stakeholders, who may have a financial interest in increasing available psychiatric care facilities. There are countless possible beneficiaries to enhancement of emergency psychiatric care in a community: public and private insurers; lawmakers and government health agencies; unaffiliated hospitals, ERs, or urgent care centers; outpatient practices, particularly community mental health centers; addiction rehabilitation centers; law enforcement and corrections; schools; etc. These stakeholders are likely to be able to provide critical insights into the care requirements of a community and may also be willing to provide funds for a PES, since they are likely to experience cost reductions by having a PES available.

In their experiences of what has become known as the Alameda Model, Zeller et al. show that following the introduction of a dedicated regional psychiatric center, average boarding time was a relatively negligible average of 1 h 48 min, and there was an overall reduction in psychiatric admissions [14]. Such centers provide comprehensive evaluation and brief treatment of psychiatric emergency patients (typically up to 24 h), either adjacent to or separate from a general medical emergency room. A bundled rate using a crisis stabilization code at \$97–140/h allows sufficient payment to cover all services, with the average patient spending 16–22 h in treatment at the center. The authors note that if one assumes an average length of stay of 20 h at \$110/h, the cost of care is less than the estimated cost of boarding (\$2264), which does not include the cost of hospitalization, the most frequent corollary of boarding.

The Alameda model provides a number of other benefits. By funneling psychiatric patients from a large area into a single center, variability in patient volume is

reduced, and a more efficient use of the psychiatrist's time is achieved. Likewise, the concentration of specialized nursing, social work, and security staff presumably lead to better and more efficient care.

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## 14.7 Summary

In sum, there is a clear need for improved psychiatric services in emergency settings; however, the specific structure of the service will be largely determined by patient volume, cost of psychiatrists and other mental health staff, institutional commitment, and participation by outside stakeholders. While on first inspection the costs of such centers seem to outweigh the benefits, direct revenue driven by PES does not accurately reflect the full financial benefit associated with providing such care, and several models have been shown to provide clear financial—and social and medical—relief for communities that have adopted such an approach. In order to determine the appropriate model for a given environment, several factors should be considered, including patient volume, additional funding sources, and indirect cost benefits to the associated hospital or medical center.

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## Abstract

As the population suffering from mental illness increases and the ability to access mental health providers becomes more challenging, telepsychiatry provides a way to meet the demands for mental health care services. Literature shows that this technology can be effective and well accepted by both providers and recipients. This chapter discusses the benefits and possible disadvantages of the use of telepsychiatry to meet the needs of psychiatric patients in the emergency room, and system requirements for implementing this technology.

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## 15.1 Introduction

The anticipated physician shortage in the United States (US) over the course of the next few decades is an accepted prediction. The population has seen rapid growth, and is expected to continue to increase faster than the expected increase in the number of physicians. To complicate matters, the current climate of health care policy and insurance guidelines encourages increased physician use by patients. In short, there are not enough physicians to see each patient who needs care. The need for care often forces patients to wait months to see an outpatient psychiatrist; these conditions may then evolve to a point where the patient must visit the Emergency Department (ED) for treatment during the waiting period.

Demand for emergency psychiatric services has outpaced supply and some patients remain in the ED (“board”) for days while awaiting placement, or even while awaiting a psychiatric evaluation. Patients boarding in an ED may not receive appropriate psychiatric care. In addition, the sheer number of psychiatric patients in the ED can result in a failure to provide emergency medical and surgical services for patients in need of urgent or emergency medical care. How can one combat this increased disparity of care? Authors have proposed decreasing wait times through increases in hospital beds, residency training positions, or higher patient caseloads. Another method for meeting this increased demand, at least when addressing the problem of the distribution of psychiatrists, is with the use of telepsychiatry (real-time videoconferencing) and other emerging methods of long-distance patient care.

Audiovisual conferencing has a long history in medical care. As early as the late 1950s, the University of Nebraska used videoconferencing to provide a variety of therapies to a state hospital [1]. In 1968, Massachusetts General Hospital provided medical care to medical facilities at Logan Airport by an interactive television link, and they provided similar services to the Veterans Administration (VA) Hospital in Bedford, MA [2]. Space Technology Applied to Rural Advanced Health Care (STARPAHC) was an initiative between NASA, Lockheed, the Indian Health Service, and the Department of Health Education and Welfare, which provided remote medical care to rural Indian Health Reservations by means of microwave, VHS radio, and telephone in the early 1970s [3]. The VA began a massive program to utilize telemedicine in the early 2000s, and by 2011, the VA documented almost 500,000 telemedicine encounters specifically to meet the needs of their mentally ill patients [4].

Despite the storied history of telemedicine, numerous problems prohibited the large-scale growth of the emerging telepsychiatry field [2]. Early telemedicine lacked federal and state regulatory oversight, and insurance did not provide funding for the necessary equipment or patient care. Without government grants, most programs did not survive. Additionally, a lack of research on efficacy and tolerability for both patients and physicians provided a disincentive for growth [2].

Technological advances at the turn of the century led to a decrease in the cost of videoconferencing software, increased speed of telecommunication, and a growing awareness of the benefits of technology. In the late 1990s and early 2000s, the decreased cost of videoconferencing software combined with the advent of

high-speed telecommunication and public familiarity with technology increased the desire among proponents of telepsychiatry to incorporate the field into daily practice. Additionally, the federal government's push for electronic medical records, the public recognition of the viability and utility of telemedicine and telepsychiatry, and the need for care in areas lacking medical expertise, garnered acceptance and adoption of newer technologies. State legislatures and medical boards now regulate the practice of telemedicine, and insurance companies provide reimbursement [5]. Telepsychiatry has been used in both inpatient and outpatient settings, including nursing homes [6], emergency rooms [7, 8], war zones [9], natural disaster sites [10], correctional facilities [11], with children and adolescents [12], and with students at rural universities [13].

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## 15.2 Benefits of Telepsychiatry

The American Hospital Association reports that in 2017, there were over 5200 community hospitals; approximately 3000 of which were non-government, not-for-profit facilities, and almost 1900 were rural hospitals [14]. Many, if not most, of these hospitals lack access to competent psychiatric care. Thus, telepsychiatry from a licensed, qualified psychiatrist is an obvious benefit.

Most perceive that the primary benefit of telepsychiatry lies in the ability to provide medical expertise to those lacking such resources. As cited above, these include rural areas, areas of natural disasters, war zones, nursing homes, and emergency rooms. Some have postulated that quality of care is decreased without an in-person patient evaluation and interaction; however, most studies have found that telepsychiatry evaluations were about 80% as accurate as face-to-face interviews [15]. A meta-review of over 200 studies that examined readmission rates with the use of telepsychiatry found that most studies had methodologic flaws [16]. The study concluded that more research was needed regarding readmissions after telepsychiatry interventions. An earlier meta-analysis found that with telepsychiatry, most patients were comfortable and satisfied with the encounters, outcomes were comparable to in-person interviews, telepsychiatry was cost-effective, and there was no evidence to show that there were increased legal concerns [17].

Some physicians are concerned about a lack of empathy conveyed over telecommunications, or that patients do not feel as though the quality of care received is equivalent [17]; however, a study of 30 children and adolescents in Canada utilizing telepsychiatry demonstrated a positive patient tolerance of long-distance medicine [18]. Many felt that the psychiatrist was well prepared before each session and was an active listener. One patient commented that the ability of the care provider to listen without being judgmental was a very positive aspect of the session. While not noteworthy in and of itself, this type of feedback is standard for in-person sessions; and this study illustrates that there is little disparity in patient tolerance. When asked about the technology itself, many participants found the ability to talk to a psychiatrist long distance was "cool." Participants also felt that they had a greater amount of "control" in the sessions. In multiple instances, patients indicated a preference

for telepsychiatry with decreased anxiety. Young adolescents not familiar with a psychiatrist often feel intimidated when meeting in person; this anxiety was markedly decreased with telemedicine. Some patients expressed a preference for telepsychiatry due to the psychiatrists being located outside of the community. Parents also express high satisfaction rates with telepsychiatric care [12].

The use of telepsychiatric services in correctional facilities has been shown to be cost-effective and successful at improving access in numerous studies. In a meta-review conducted in 2013, Deslich and colleagues examined 49 studies of telepsychiatry in correctional facilities [11]. Correctional facilities have long lacked access to the psychiatric care required for this special population, with the largest barrier to care cited as cost. The cost of psychiatric care to correctional facilities includes facilities, personnel, and the availability of workers to travel to and from the facilities each day. When prisons implemented telepsychiatry for inmate care, they saved up to \$1 million in cost. Additionally, several studies in this meta-review report that inmates frequently prefer telepsychiatric services because they are able to meet more often with a mental health care provider. In short, improved access increases patient satisfaction with services, and telepsychiatry achieves both [11].

In the Emergency Department specifically, telepsychiatric services significantly decrease delays in access to care for patients in rural facilities. Southard et al. demonstrated that order to consult time in a rural hospital decreased 68% from over 16 to 5.4 h after the implementation of telepsychiatry [19]. There were similar decreases in length of stay in the ED, and door to consult times. As a result, patients had 24-h access to specialty care for their psychiatric illnesses.

The American Psychiatric Association (APA) website lists numerous other advantages to telepsychiatry, especially in the ED setting [20]. Access to qualified psychiatrists who are not otherwise available provides treatment with a decrease in morbidity. Shorter time in the ED means less time away from family and work obligations. Adequate and appropriate treatment also means that the individual is less likely to return to the ED and more likely to receive mental health follow-up. The American Hospital Association (AHA) reports that states utilizing telepsychiatry in rural EDs have decreased the number of commitments for inpatient psychiatric hospitalization and improved patient satisfaction [21]. Another source cites decreased expenses for hospitals because of increased treatment and discharge of psychiatric patients from the ED, and faster treatment of mentally ill patients [22]. Furthermore, psychiatric patients with prolonged length of stays may take up valuable bed space in the ED. This limits the ability of ED providers to care for medically ill patients, and results in a loss of income. The use of telepsychiatry promotes the effective disposition of psychiatric patients.

In addition, telepsychiatry in the ED can aid tremendously in public health emergencies when access to medical care is decreased or even unavailable. Yellowlees et al. report that telepsychiatry and telemedicine can be indispensable in emergency medical planning on the local and national level [23]. Many point to the problems with access to care specifically in the aftermath of Hurricanes Katrina and Rita in 2005. Chronically or acutely ill psychiatric or medical patients in the affected areas did not have access to medical care, counseling, medications, or emergency

psychiatric evaluations after the hurricanes. Telepsychiatry via portable psychiatric terminals can provide care in such instances. While the utility of telepsychiatry is recognized by the Federal Emergency Management Agency (FEMA) and other emergency medicine organizations as a viable option in public health emergencies, a review published in 2019 by Reinhardt and colleagues concluded that more training for emergency telepsychiatry is needed in these situations [8].

At the time this goes to the publisher, telepsychiatry and telemedicine are being utilized widely in the US during the coronavirus (COVID-19) pandemic. Due to the necessity of physical distancing (avoiding large gatherings and maintaining a distance of at least 6 ft from other individuals) to limit spread of the disease, many hospitals, physicians, and academic centers are using telemedicine to contact and evaluate patients instead of using in-person appointments. Due to the grave emergency situation, the US federal government and Medicare are encouraging the use of telehealth by easing restrictions and billing requirements. Non-HIPAA-compliant software, such as Skype and FaceTime, is approved for use during the crisis. Some hospitals are also using the software for inpatient or ED encounters to provide less exposure to health care workers. This is an ongoing situation, however, and research will be needed on the effectiveness and limitations of the expanded telehealth capabilities.

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### 15.3 Technical Considerations

Barriers to early adopters of telepsychiatry were technological considerations, guidelines, and the costs associated with startup. In this new millennium, costs for the minimum necessary technical equipment for telepsychiatry have gone down, and improved technology allows for increased options for providers and patients.

Psychiatry, as a field, is based on the relationship between the psychiatrist and patient. Psychiatrists rely a great deal on their observations of patient appearance, behavior, and any abnormal mannerisms to make accurate assessments. Based on these requirements, telepsychiatry equipment must be reliable and of a certain level of quality; therefore, the necessary equipment includes, at a minimum, video cameras with monitors, microphones, and speakers at both sites [24]. Additionally, because all equipment in the US must be Health Insurance Portability and Accountability Act (HIPAA) compliant, audiovisual and encryption software are also required at both sites to maintain the confidentiality of patient health information [25]. If telepsychiatry is being utilized between countries, the standards of confidentiality of both countries must be maintained [26]. For psychiatrists who are using a telepsychiatry company provider, the physician must maintain a copy of the Business Associate Agreement (BAA) to verify the company will meet the required HIPAA and state standards [27]. Skype, a commonly used video chat modality, is not HIPAA-compliant as there is no available BAA [28]. As noted above, however, the US federal government is allowing the use of non-HIPAA-compliant software (Skype and FaceTime) during the coronavirus pandemic in order to facilitate the use of telehealth and lessen the spread of the disease.

Due to the increasing demand for telemedicine in the US, companies are developing high quality audiovisual systems to meet the requirements. Polycom is one company frequently used for audiovisual capabilities [24]. Likewise, business companies develop networks and contracts with hospitals, emergency rooms, and clinics to meet telepsychiatry needs. These companies frequently provide the equipment, help the physician obtain state licensure and hospital staff privileges, and maintain the contracts with the systems that need care. Telepsychiatry is now a career choice for many psychiatrists. Literature and organizational websites, including the American Psychiatric Association and the American Telepsychiatry Association, provide more information and guidance for those contemplating the use of telepsychiatry [24–27, 29–32].

Technical guidelines include the need for alternatives in the event of equipment breakdown [27, 32]. These guidelines also reiterate the need for security for protected health information. One of the guidelines not touched upon previously is the requirement for the physical location of telepsychiatric services [28]. Both the patient and provider rooms need to be secure and have the privacy required for the examination; both areas are examination rooms and should be treated as such. Both sites should be soundproof so others cannot overhear the conversation.

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## 15.4 Legal Considerations

Physicians and facilities who wish to establish a telepsychiatry service face a myriad of details. In addition to the requirement for HIPAA-compliant software already mentioned, all parties need to have arrangements for record storage and security. Whether paper or electronic, all sides need to be aware of the need for consent before the information can be released [27].

Physicians will frequently evaluate and treat patients who are located in different states or even different countries [27, 28]. Generally physicians must be licensed in the state or country where the patient is physically located, as well as the state or country where the psychiatrist is present when evaluating the patient. Though current policies may allow for the psychiatrist to provide care and bill for telepsychiatry patients in the US, the market and insurance requirements can change rapidly, and the psychiatrist needs to be aware of changes in billing and/or prescribing. Additionally, both the facility and physician need malpractice insurance, and it is incumbent on the psychiatrist to determine if their current malpractice insurance covers the practice of telepsychiatry. The physician may have to add a rider to the existing policy, or obtain a separate malpractice policy for telepsychiatry.

Physicians must be aware of the commitment laws, “duty to warn” requirements, and medication regulations in the state where the patient resides and is seen [32]. Psychiatrists providing telepsychiatry care must also be aware of the differences in prescribing regulations across states. The Ryan Haight Online Pharmacy Consumer Protection Act of 2018 requires that controlled substances only be dispensed with a valid prescription. A valid prescription requires an examination of the patient by the physician [26–28]. In addition to a medical license for the state where the patient is

located, the psychiatrist must have a Drug Enforcement Agency (DEA) and state-controlled substance license in that state in order to prescribe controlled substances. In the US, many jurisdictions require the physician to check the Prescription Monitoring Program (PMP) before prescribing controlled substances. If the area where the patient is seen is in a different state, the psychiatrist may have to access multiple PMP databases. An additional burden is the requirement for the psychiatrist to obtain hospital staff privileges for every facility where patients are seen via telepsychiatry.

Another legal consideration in the care of the psychiatric patient is whether the patient has access to firearms [32]. The physician should discuss with the patient, and family if available, whether there is a gun in the household and, if so, where the ammunition is located. Ideally, the firearm and ammunition are not colocated. If there is a firearm in the house, the physician must also ascertain whether or not the family can remove the firearm, or keep it under lock. Even if the patient or family does not own a firearm, the provider should have some awareness of how easily the individual may obtain a firearm. As one can see, legal requirements for the provision of telepsychiatry are numerous and can be challenging for all parties.

Psychiatrists must also be aware of the “duty to warn” requirements in the patient’s location [32]. If the patient voices threats to hurt anyone, “duty to warn” requires the psychiatrist notify the party threatened and the police department in that locale. Many, if not all, of these individuals will require inpatient psychiatric hospitalization. Psychiatrists are mandatory reporters; if a suspicion exists that the individual poses a danger to children, elderly or disabled individuals, or the individual being evaluated is a minor or dependent and the victim of abuse or neglect, the physician is required to contact the appropriate agency (police, Adult Protective Services, Child Protective Services, or Elderly Protective Services). Locales vary as to the requirement to notify authorities in cases of suspected domestic abuse.

A final legal consideration is the issue of consent. Experts recommend that the patient gives permission for the telepsychiatric interview and for treatment [26, 27]. While a suicidal or violent patient who requires evaluation may lack the capacity to give consent, other patients are able to consent. The psychiatrist should obtain informed consent for the interview and the treatment whenever possible. Table 15.1 provides a summary of the pertinent legal considerations for the physician.

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## 15.5 Cost Considerations

The use of telepsychiatry can cut costs by decreasing wait time for patients with behavioral health complaints, and length of stay in the ED; however, substantial costs may be incurred by physicians and hospitals. There is an initial startup cost for the equipment, secure record maintenance, and storage for the physician and hospital. Hospitals must then either contract with companies that have psychiatrists available to provide telepsychiatry services, or recruit and hire physicians specifically for telepsychiatry positions. The hospital also absorbs the costs of reviewing credentials and maintaining staff privileges for physicians from different geographical



**Table 15.1** Preliminary considerations for the physician

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• Do I have the necessary videoconferencing equipment with sufficient bandwidth to provide HIPAA-compliant care?
• Do I have the necessary credentials for the hospital facility?
• Do I have a current, valid license to practice medicine in the state where the patient is located? Do I have the necessary state- and federal-controlled substance permits in that area to prescribe controlled substances?
• Does my malpractice coverage include telepsychiatry or will I need a separate rider?
• Do I have a way to keep records in a HIPAA-compliant manner?
• Is my interview location private and secure, an appropriate patient examination room?
• Do I have backup arrangements for technological failures?
• Has the patient signed a consent to telepsychiatry interview/examination?
• How will I verify the patient's identity and location prior to the interview?
• Do I have a way to contact hospital security and personnel if the patient poses a danger to self or others?
• What is the procedure to notify protective services if necessary?
• How do I contact legal authorities and individuals in danger to fulfill my "duty to warn?"
• What are the state commitment laws?
• Will the patient have medical clearance prior to the interview?

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areas. The psychiatrist must spend time and money to obtain state medical licenses, and DEA and state-controlled substance licenses for every state where they will practice or subcontract with a telepsychiatry company. Thus, although all losses will likely be recouped, one must take into account the initial costs involved before making the decision to commit to utilizing telepsychiatry.

---

## 15.6 Emergency Considerations

Telepsychiatry is well suited to the ED setting as the establishment of early mental health care is correlated with improved patient outcomes. The development of proper guidelines for contacting psychiatrists using telemedicine and emergency care algorithms is essential in any situation where emergencies can arise. This applies to both emergency room care and the outpatient setting, as patients can present with new emergency symptoms in an established relationship with a telepsychiatric provider. When developing guidelines for telepsychiatric care in the emergency room setting or in emergent situations in outpatient care, there are administrative, legal, ethical, and clinical considerations, as well as features specific to rural populations.

Administrative issues to consider when establishing emergency telepsychiatric care include emergency protocols, availability of resources, and delineation of staff roles [32, 33]. Providers should be aware of site resources, such as the presence or absence of security, staff expertise in handling psychiatric emergencies, and availability of outpatient follow-up care. A psychiatrist evaluating a patient in the ED by

telepsychiatry must know how to contact additional emergency personnel in the event of a medical or psychiatric emergency. Likewise, the telepsychiatrist must know what medications are available on the hospital formulary in case a patient becomes dangerously agitated during the assessment. Ideally, the psychiatrist should have a relationship with the staff on site and some familiarity with the facility. This includes knowledge of the staff's level of comfort and expertise in caring for individuals with psychiatric illness. It is also important to know what the facility has to offer for medical care and laboratory and radiology services. Availability of aftercare resources following evaluation is essential, as the psychiatrist discharging an individual must know whether the patient will have a follow-up appointment in 2 weeks or 2 months. Other knowledge requirements include availability of facilities if psychiatric hospitalization is necessary, and pharmacies for outpatient medications. The psychiatrist must also ascertain how information is communicated to the outpatient physician once the patient is evaluated and discharged from the ED.

Though the physician is separated from a violent or agitated patient by technology and distance, facility safety, including patient and staff safety, is a priority. Physicians should have a way to quickly inform staff of dangerous situations, although generally, a staff member handles the telepsychiatry equipment and is present with the patient at all times. The Joint Commission also warns of the potential for suicide in facilities [33]. In order to reduce the risk of suicide, the psychiatrist and hospital staff should discuss and agree upon what type of supervision is indicated for the patient. The interview room should be free of all tubing, extension cords, intravenous lines, and any item that the patient could use to hurt themselves. Since telepsychiatry equipment requires electricity, the potential exists for hanging or choking by means of the electrical cords present. Even antibacterial sanitizers pose a safety risk as individuals may drink the contents and develop acute alcohol poisoning. Seemingly innocuous items such as hardware and doors in the room may also provide a means for the psychiatric patient to die by suicide. Patients may climb through ceiling tiles in order to escape. Despite the physical distance, the psychiatrist must be vigilant to all potential safety concerns in the examination room [32]. Practical considerations include a plan for seclusion and restraints of the patient if necessary, although it is important to note that hospital policy must be consistent with federal and state regulations regarding seclusion and restraints. Emergency room physicians are usually amenable to order restraints and/or seclusion if necessary, and to provide any necessary on-site monitoring.

Finally, substance abuse is often comorbid with many psychiatric conditions and well known to exist in all geographic locations. Physicians may have a challenging time addressing these issues as rural locations often lack the resources and diagnostic tools that are accessible in urban areas. Telepsychiatric providers in urban areas with more local resources often find themselves having to take primary lead on substance abuse assessment, diagnosis, and treatment in their rural telepsychiatric experiences [33]. Table 15.2 presents a sample checklist for emergency considerations and protocol.

**Table 15.2** Emergency considerations for telepsychiatry

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• What is the availability of security and/or police?
• Is the examination room free from any items that the patient could use to harm self?
• Will a staff member be present with all patients at all times?
• Does the facility have the capability to do laboratory, radiologic, and electrocardiogram?
• Are panic buttons available in case of emergency?
• What psychiatric medications are available for oral or intramuscular administration?
• What equipment is available for technical failures?
• How soon will the patient be able to receive outpatient follow-up once released?
• Are there facilities available for inpatient psychiatric hospitalization if required?
• Will the patient have the opportunity to leave with prescribed medicines? If not, are there local pharmacies, especially those open 24-h?
• Is there a way to obtain collateral from individuals close to the patient regarding recent behavior, access to firearms, and other safety information?
• Is there a backup plan for electrical or technological equipment at both sites?

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## 15.7 Summary

Telepsychiatry has a long history at the forefront of telemedicine services. Multiple studies and trials show that patients and providers tolerate the experience, and in some instances, prefer this method to traditional encounters. Telepsychiatry is highly cost-effective and has been shown to increase access in rural and prison populations. Though limited, the studies of emergency telepsychiatry specifically demonstrate that its use increases access in disaster situations, and decreases patient ED wait and stay times in critical access hospitals.

Like other modes of health care delivery, telepsychiatry comes with technical, privacy, legal, and ethical concerns. Telemedicine services require high standards of audiovisual fidelity which is constantly evolving in today's market. When setting up telepsychiatry services, hospitals are also required to adhere to HIPAA and other legal standards in technical, situational, and environmental considerations. In Emergency Departments, telepsychiatry requires the establishment of guidelines that enable staff to be able to safely manage and treat patients without a psychiatrist on-site prior to implementation. Finally, providers in the ED must keep in mind the potential discrepancy between rural sites and the providers' likely urban location.

In summary, telepsychiatry holds promise for the future of Emergency Department psychiatric care, and can address the problems of accessing care in rural and disaster settings. Like every other mode of care in medicine, it has its limitations, but the promise of increasing access to specialty care is an exciting advance in the field of psychiatry.

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# Identifying and Understanding Legal Aspects of Emergency Psychiatry Unique to Different Jurisdictions

# 16

John Samuel Rozel

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## Abstract

More than any other clinical specialty, emergency psychiatry relies heavily on the legal system not just to circumscribe the boundaries of practice, but also as the very tools of its work. Involuntary commitment, protection of confidentiality, notification of third parties, and more are essential interventions for emergency psychiatry. These legal processes are subject to a hierarchy of laws, ranging from national constitutions down to municipal laws and are interpreted through the lens of culture, custom, and risk tolerance. As a result, jurisdictions even within the same country or state may adhere to very different legal standards. Understanding these regional variations, some explicit and others quite subtle, is essential to the practice of emergency psychiatry. This chapter will explain how

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and why such variations arise and how exploring these intricacies as a collaboration between the clinical team and legal counsel can lead to successful operations and mitigation of risk.

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## 16.1 Introduction

Psychiatric emergencies are handled in a variety of settings including general emergency departments (EDs) and specialized psychiatric emergency services (collectively referred to hereafter as PES). All of these services are delivered in a context and environment of clinical standards and nonclinical constraints, both of which vary significantly based on a number of factors. They form, in essence, a *terroir*: the combination of science and environment that shape the development of a PES much as a vineyard. Much as the viticulturist must adapt technique and goals according to the local *terroir*, so too must an emergency psychiatrist adjust their approach accordingly.

While forensic pathology and forensic psychiatry are fundamentally linked to the law, few clinical specialties are as inextricably linked to regional laws and regulations as emergency psychiatry. Emergency psychiatrists deal routinely with questions of consent, confidentiality, involuntary commitment, and related issues. Such matters are intrinsic to emergency psychiatry, and it is difficult to successfully provide emergency psychiatric services without some degree of legal acumen.

Clinical standards and questions will be addressed throughout this book. The focus of this chapter, however, is how to systematically and strategically understand the legal constraints which impact the delivery and outcome of emergency psychiatric care. Specific legal rules vary greatly based on jurisdiction and evolve and change over time; it would be impractical to provide a detailed list of rules for the diversity of jurisdictions to be considered as the research would be onerous, the content expansive and detailed, and the laws and regulations subject to change. Rather, this chapter will explore fundamental concepts relating to medicolegal decision making and provide a number of areas and questions that each provider will need to consider and understand for their own setting.

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## 16.2 Considerations on Risk

Risk in life is inevitable. Risk in emergency psychiatry is essential. Every time a decision is made to admit a patient, it is balanced against the risk of not admitting. Admission is chosen, perhaps, because of a concern of suicide or violence. The clinician postulates that there is a greater risk should the patient not be admitted and hopes that the risk of suicide or violence is lower during, and after, the admission. That hypothesis is tempered by the reality that suicides occur infrequently in inpatient units and perhaps more frequently in the days and weeks after discharge [1, 2].

There is little in the way of randomized clinical trial evidence to guide clinicians, but the lack of evidence should not be paralyzing; in truth, some hypotheses can never be reasonably tested [3, 4].

Perhaps equally important is understanding the importance of recovery as a process and the critical importance of a person being actively engaged in that process themselves [5]. While thresholds for admission could be low and for discharge high, beds would fill quickly and PES would fill with boarders awaiting care. But growth and recovery are difficult to achieve in the presumptively safe environs of inpatient settings, and part of the dignity of being a person is, within bounds, to accept one's own risks [6, 7]. Put simply, there are times where short-term risks must be accepted in order to achieve long-term gains. The difference between a system focused on short-term safety and risk avoidance will produce different, and arguably worse, outcomes over time than a system focused on long-term recovery; the latter outcome, however, likely will not be achieved without some short-term adverse outcomes.

Some patients present in acute thralls of illness defined largely by their mood or psychotic disorder; others have prolonged courses of complex illnesses, often confounded or driven by personality. Admission may be an ideal intervention for acute risk and an unproductive, if not counterproductive, intervention for chronic risk [8]. The challenge is that both of these patients may present similarly in their evaluation; an understanding of their history—optimally through a timely review of documentation—will be needed to clarify the nature of the presentation.

All of these risk-related heuristics take place in the context of the culture and constraints of the law of the region in which it occurs. It requires timely, mindful, and efficient processing of varying, inconsistent, or incomplete data sets. It requires operating in a cognitive domain with subject matter complex in both the colloquial and scientific sense of the word. And it requires that the psychiatrist juggle probabilities, frequencies, and risk estimations in ways that invite error and cognitive bias while under pressure and duress [9–11]. Such work is challenging and requires temperance lest the clinician fall prey to overconfidence [12, 13]. Effective management of risk requires balancing clinical and legal rules and applying judgment to the significant uncharted territories presented in the outlier cases that become common in the PES. Careful attention to personal and staff wellness and performance under pressure is essential [14, 15]. Consideration of the science of risk and decision making is a critical area of expertise for the emergency psychiatrist [16–18].

Every decision is a calculated risk. In the realities of the emergency psychiatry clinical environment, there is no genuinely risk-free pathway – despite how easily a clinician can fall into the zero-risk bias trap [19]. In ideal situations, the risks of possible choices are comparable in some way (e.g., 20% risk of suicide with plan A, 80% risk with plan B), but this is not always the case. Calculating immediate and long-term risk, comparisons between deterrent effects of admissions and alienating effects of coercion, and similar challenges often make certainty impossible. Effective clinical practice requires awareness of this process and the capacity to communicate this understanding to others verbally and through the medical record.



## 16.3 Understanding the Clinical Context

Every clinical encounter takes place in a context—patient factors; provider factors; the ecology of the PES both internally and in relation to inpatient beds and community resources; cultural norms, clinical preferences, and styles; and ultimately legal constraints as well. Variations in any one of these elements can change the disposition even with an identical presentation [20, 21]. Some of these are determined by the enacted law of the land—the nation, state/province, or municipality. Some of these are determined by less explicitly defined rules emerging from culture and social norms—both of the community surrounding the hospital and within the clinical team itself. These factors directly impact the risk awareness and risk tolerance of a PES and its clinicians. Risk awareness, in turn, guides how laws are interpreted and applied. Awareness of all of these factors directly supports improved clinical decision making by clinicians.

Every PES has critical external relationships within the hospital and across the community. Explicit efforts to develop and support open communication and collaboration can be essential in developing a PES that can weather and survive the inevitable challenges, outlier cases, and adverse events. Alignment between PES leadership's values and perception of risk with both frontline clinicians and hospital leadership is crucial and may be supported by clearly identified goals, mission, and values [22].

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## 16.4 Getting Good Advice

Perhaps the most important external relationship is with legal counsel. Effective practice of emergency psychiatry benefits from a solid understanding of legal principles and appropriate laws and regulations, but the psychiatrist's expertise must ultimately be in clinical science and decision making. Legal counsel that can provide objective interpretation and guidance that is timely, clinically pragmatic, and factually correct is critical even for the most legally savvy clinician.

All lawyers, however, are not created equal. Legal counsel with a prudent and practical understanding of risk theory and decision making and an appreciation of the challenges, complexities, and realities of in-the-trenches emergency psychiatry is ideal but may be difficult to find. A risk-averse legal counsel sees the law for its constraints; a risk-comfortable legal counsel sees the law for its opportunities.

As a starting point, seek effective counsel from those who understand health law and the values and priorities of a PES. Nourish the collaborative relationship and help them understand areas of particular interest to PES operations as they develop into experts on mental health law as well. Work with hospital administration and leadership to help obtain and retain effective and accessible legal expertise. It will be this legal counsel that will help PES psychiatrists and leadership design the program and navigate the day-to-day queries that arise during continued operations.

## 16.5 Critical Questions

What follows is a list of important domains of medicolegal interest important to the successful operation of a PES. Policies and procedures may be helpful to codify some answers, but in a dynamic environment like a PES, they must be flexible and deviation from established guidelines should be permitted when appropriately justified [23]. Advanced planning for various scenarios provides frontline staff with consistent, ethical, legal steps rather than improvising such steps under duress. Often, significant gains are made purely from the process of planning, even if impractical in the face of an outlier case. Each program will need to consider which guidelines can be overwritten by frontline clinicians in real-time (and with appropriate justification) and which require the input of leadership. Real-time consultation with clinical leadership and legal counsel for challenging cases should be the goal, even with the difficulties presented by the need for 24/7 operations and accessibility. Certainly, in the management of a crisis, there is much to be said for working with an established team rather than creating new relationships in the midst of an emerging problem.

Consider each of these questions the stem of a conversation between PES leadership and legal counsel as one builds or operates a PES and as a hospital attorney develops their expertise in the somewhat nuanced niche that is emergency mental health law.

1. **What is the jurisdiction?** The legal context of any clinical decision may be subject to a number of hierarchical laws and regulations, from national laws and constitutions, state and provincial laws, and municipal and local codes. Constitutions generally take precedent over national laws which generally take precedent over local laws. How these legal standards are applied, enforced (in case of civil litigation or criminal prosecution), and how adherence to or deviation from the law is reviewed, or adjudicated, varies significantly between and within nations. Legal standards for commitment in England will be different from those in Ecuador. Duties to third parties will vary between Connecticut and California, and even more so in Catalonia.
2. **What other jurisdictions are important?** Legal standards for commitment, confidentiality, and so forth will generally only apply within a specific jurisdiction. Understanding, at least superficially, how critical laws apply in immediately adjacent jurisdictions can be useful. This is particularly important when the borders are close to the PES and easily permeable (e.g., states in the Northeastern United States, nations in Western Europe). Regions with dispersed populations, multiple jurisdictions, and limited specialty hospitals (e.g., the Caribbean) may also face similar issues. Finally, programs that provide or utilize telepsychiatry services may need to be especially mindful of jurisdictional boundaries and rules, laws, or standards. Relevant standards include not only the site of care but also the site of the telepsychiatry company and potentially the location of the company organizing the service as well.

3. **Who can consent for voluntary evaluation and treatment?** Most medical ethics systems prefer autonomy and individual rights over involuntary interventions. The right to voluntarily consent to evaluation and treatment can vary based on a number of locally determined factors including, but not limited to, age, guardianship status, marital status, military service, impaired decision making, presence or absence of certain symptoms or illnesses, prior involuntary commitment or current outpatient commitment, and criminal/legal status. Ethically, informed consent is often recognized as the relevant standard for voluntary decision making, but interpretations may vary by region [24].
4. **What are the standards and processes for initial involuntary evaluation and treatment?** Many jurisdictions will have legal standards and procedures establishing when and how a person can be involuntarily examined or admitted for psychiatric illness, what the time constraints may be, and what due process rights, including rights of appeal, may exist. Most legal and ethical systems prefer autonomy over involuntary interventions and create legal and procedural safeguards to limit the use of involuntary interventions. Standards may vary for *parens patriae* interventions (to protect a patient from harm against self) and police power interventions (to protect others from the patient). Jurisdictions will also vary in how ongoing clinical decisions are made for involuntarily committed patients—are they made by the physician, other health care providers such as advanced practice nurse/psychologist, a guardian or executor, by the court, or by some other party or process. Involuntary commitment does not necessarily imply a complete loss of medical decision-making rights for the patient. And, of course, the consistency of adherence to any law or regulation may vary significantly within a jurisdiction due to variabilities of interpretation and understanding. Nonetheless, involuntary evaluation and commitment is often the most important legal tool in emergency psychiatry and PES providers must understand the various nuances.
5. **What are the rules for confidentiality and privilege?** Confidentiality generally describes the responsibility of the clinical team to keep sensitive information from inappropriate disclosure to uninvolved parties. Privilege is the right of the patient not to have otherwise confidential clinical information used against them in a legal context. They are overlapping but different protections. Many jurisdictions recognize, by statute or case law, broad protections of confidentiality and privilege for mental health communications between patient and provider. Rules may vary for observations, physical findings, and communications with non-mental health medical providers. Some jurisdictions also expressly create specific exceptions to confidentiality and privilege, including for the purpose of involuntary commitment, mandated reporting of past child or elder abuse, and when disclosure is necessary to protect third parties from future harm by the patient.
6. **How are medical or psychiatric advanced directives identified and handled?** More and more jurisdictions are permitting and promoting the use of advanced directives to allow a patient to express his or her wish for treatment prior to being disabled by medical or psychiatric illnesses. It is important to

understand if such legal documents are allowed in the local jurisdiction and how they may impact clinical decision making for a patient presenting with a psychiatric or medical emergency [25, 26].

7. **What are the duty to third party considerations?** Many jurisdictions have rules about duties to third parties that may derive from statute, judicial decision, regulation, or professional ethics. Questions about such duties commonly arise when a clinician is aware that a patient intends to severely harm an identified or readily identifiable third party, as in the famous American case, *Tarasoff v. Board of Regents* [27, 28].
8. **What are the relevant reporting requirements for violent injury and abuse?** Many jurisdictions mandate health care professionals report abuse or neglect of children or the elderly. Some jurisdictions also require reporting of certain types of violent injury such as penetrating stab wounds or firearm injuries. Understanding what types of injuries, abuse, or neglect are reportable is necessary and often warrants specific policies and staff training.
9. **Do impaired motor vehicle operators need to be reported?** Various jurisdictions may have requirements to report patients whose safe operation of motor vehicles—from automobiles to airplanes—is impaired by acute or chronic illness [29]. Other jurisdictions may have strict confidentiality rules limiting any such disclosure even for operators in high-risk settings [30, 31]. This may apply not only to identified patients but also to the situation where an intoxicated friend or family member presents to pick up a patient being discharged from the PES.
10. **What are the rules for firearms?** Access to firearms is an important risk factor for suicide and violence [32]. Firearm laws vary significantly across nations and, within the United States, across states. PES teams need to understand the impact of voluntary or involuntary commitment on firearm access, alternate pathways for removal (e.g., gun violence restraining orders), and, for providers in high gun ownership nations like the United States, how to effectively assess and manage risk. While civilian-owned firearms are most numerous in the United States, they are potentially accessible in any country, especially by people connected to law enforcement or the military [33].
11. **What are the liability concerns for medical malpractice?** Varying regions have different legal standards and processes for determining malpractice, apportioning liability, and frequencies or risks of legal liability in general. While psychiatry is a lower-risk specialty, emergency work may increase that risk [34]. The professional impact on a psychiatrist found liable in a malpractice claim can be significant. Checking the background and malpractice history of a licensed professional across jurisdictions poses challenges but is an important part of the credentialing and vetting process for any new hire.
12. **What type of malpractice insurance should be obtained?** Some jurisdictions permit or require hospitals or individual professionals to obtain malpractice insurance policies. Insurance specialists can provide detailed advice in obtaining and maintaining such a policy. Clinicians and, especially, clinical leaders should seek to understand the who, what, when, and where of coverage. Who is

covered (attendings, all staff, trainees, etc.)? What types of errors or outcomes are covered (e.g., sexual misconduct or criminal allegations may not be covered)? When is coverage in effect (claims based vs. occurrence-based; tail and nose coverage)? Where is coverage in effect (particularly important for telepsychiatry)?

13. **After adverse events, how is disclosure or apology handled?** There is some promising evidence that a properly delivered apology to a patient or family after adverse events may decrease risk for liability as can diversion to mediation or arbitration [35, 36]. Expectations and standards will vary significantly for legal, cultural, and ethical reasons across settings. It is important to understand if apologies are appropriate in the setting in question, and, if so, to develop tools and guidelines for determining when, how, and who should deliver such messages [37].
14. **How long are relevant statutes of limitations?** A statute of limitations determines how long a person or organization is potentially at risk for a civil or criminal action after an alleged event. The duration of this exposure varies based on civil or criminal nature, the type of infraction considered (e.g., criminal or civil liability for sexual abuse may be much longer than for simple negligence), and may not even be specifically enumerated in each jurisdiction. The statute of limitations can impact decisions relating to malpractice liability exposure, insurance coverage, and records retention policies.
15. **Are there legal, professional, or ethical guidelines for the transfer of patients between facilities?** Transfer of psychiatric patients between facilities can be confounded by insurance and payer issues, clinical stability, bed availability, and legal commitment status—all of which are complex within a given jurisdiction and even more challenging across borders. Failure to adhere to known guidelines can expose the PES to significant liability and risk.
16. **How are law enforcement officer (LEO) interactions handled?** LEOs can interact with PES programs by bringing patients for evaluation (voluntarily or involuntarily), investigating crimes involving patients (suspects, victims, or witnesses), transferring involuntary patients between hospitals or to or from jails and prisons, collecting and transferring evidence (including access to medical records), responding to internal and external disasters (e.g., mass shootings or civil unrest), providing on-site security, and, in some settings, may even act as sitters for psychiatric patients boarding in the emergency department (ED) for an inpatient bed. Despite the regular and close interaction between ED staff and LEOs that often occurs, there are also a number of risks from conflicting roles, values, priorities, and professional cultures [38]. Clear guidance for staff on how to work with (or limit) LEOs in the care of the emergency psychiatry patient can be helpful. It may be optimal to develop ongoing dialogues and relationships between PES leadership and their counterparts in local LEO agencies.
17. **How are services paid for?** Every hospital and clinical service needs to be mindful of sustainable financial operations, charitable mission notwithstanding. Laws and standards will vary greatly, as will availability of insurance or

state health programs to fund services. Billing of patients or families for services may be necessary or customary but is also fraught with ethical risks. Aggressive debt collection practices, while possibly legal, may be equally ethically dubious [39]; PES leadership needs to be mindful that the values of their service area may be in conflict with those of the operating hospital. Delaying evaluation or treatment in an emergency due to questions around the ability to pay may be unethical or illegal in some settings.

18. **How are patient rights protected?** Many of the questions above are intended to illuminate how legal systems and services support and protect the mission of the PES. The rights of patients also need to be protected, even recognizing that these, at times, are the countervailing force opposing paternalistic psychiatric interventions. While embracing these differences may seem unusual, consistent respect for the legal and ethical rights of patients can protect the PES from complaints, litigation, and other investigations.
19. **What are the other general legal issues faced by any clinical service that are also applicable to a PES?** While a PES has specialized legal concerns, they are not immune to the routine legal issues affecting all health care settings. These include, but certainly are not limited to, employment law, workplace safety, and health standards, billing issues, zoning regulations, building codes, and even food preparation, hygiene, and waste disposal matters.
20. **What are the other jurisdiction-specific issues that are not covered in this list that may be relevant?** In essence, what else should be on this list? Ideally, any competent legal counsel will enter the relationship with broad knowledge of the issues of health care law even if they are only beginning to develop their expertise in mental health law and issues specifically related to the PES. Good legal counsel can help PES leadership teams continue to recognize and manage potential legal risks during the design and ongoing operation of the program.

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## 16.6 Summary

The 20 questions above are a starting point: neither definitive nor complete. They are intended to provide a framework for a situational awareness assessment of a program's legal terroir and a structure for initial discussions between a PES leadership team and their legal counsel. Inevitably, even the most complete initial situational appraisal will become incomplete with ongoing operations. Novel clinical situations are routine in emergency psychiatry. Laws are revised, court opinions shift, and risk tolerance fluctuates due to changes in the environment and in the team members. These and other factors impact the terroir which the PES leadership must understand as they cultivate their program.

This is not to say that clinicians need to be legal experts. Mastery of the clinical science of emergency psychiatry is daunting enough without aspiring to a second parallel career. Rather, it is to say that expert legal counsel should be seen as an essential part of the leadership and operational team in the PES.

Concentrating expert knowledge in clinical and legal aspects of emergency psychiatry, risk issues, and clinical matters in the PES is ideal. Expert teams will routinely outperform diffuse organizational networks of knowledge or expertise [40, 41]. And, when done well, emergency psychiatry is tremendously engaging for the provider and lifesaving and protective for patients and communities.

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# Special Populations in Psychiatric Emergency Services: Children and Adolescents

# 17

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## Abstract

This chapter highlights the current state of child and adolescent emergency psychiatry, specifically the increase in pediatric psychiatry emergency room visits, and describes the roles the various emergency systems that assess and care for youth need to fill in this context. The authors also aim to enumerate the treatment modalities, types of staff, and interventions best suited to treat this population. The text also addresses the need for a greater investment in resources, both in infrastructure and specialized provider training, to allow for the implementation of innovative and efficient solutions to this growing gap in care.

## 17.1 Introduction

Children and adolescents with emergent psychiatric needs, and the emergency departments (EDs) that serve them, are facing a crisis. Pediatric psychiatric emergency room visits have seen a sharp increase over the past 20 years. From 2006 to 2011 alone, visits rose by over 20%. Estimates indicate that youth with acute psychiatric needs now account for 2–5% of all pediatric ED visits, totaling over 800,000 visits per year [1–4]. In this chapter, the term “pediatric” is used to describe patients under the age of 18.

There are multiple factors at play in the increased utilization of emergency services for this population. One contributor may be the increase of suicide as a cause of death among children and adolescents; it remains the second leading cause of death for people between the ages of 5 and 24 [5]. Suicidal ideation and behavior have also been increasing among younger children, particularly in young, black male children [6].

Acute aggression is another frequent factor that brings youth to the ED, often for repeat visits, which may be another component of the problem [7]. ED staff struggle to contain and de-escalate aggressive patients without the use of restraints, so much so that 1 in 15 youths in the ED for psychiatric complaints receives sedative medications or is physically restrained during their stay. Such restraints carry a high risk for morbidity and mortality, and are distressing to youth, families, and ED staff [8].

Youth with complex symptomatology, including mania, psychosis, delirium, or severe behavioral disturbance in the context of developmental disorders or significant intellectual disability, put strain on EDs in multiple ways. They may need immediate management for their physical safety, creating a staffing demand, while at the same time requiring intensive medical and psychiatric workups to narrow wide differential diagnoses, ranging from seizures to autoimmune encephalitis [9].

Why are more youth presenting to EDs for psychiatric symptoms instead of to other settings, and why are they presenting at such high degrees of complexity? Over the last few decades, mental health services for children and adolescents have been restricted and cut. This is especially true for acute outpatient services such as partial hospital programs or intensive outpatient programs. Additionally, the permitted length of stay in a range of treatment settings, including inpatient, residential,

state hospital, and day treatment levels of care, has been reduced. As a result of these constraints, families, schools, and (when they exist) outpatient providers are often at a breaking point, feeling unable to care for the youth due to the severity of symptoms and behaviors, and bring them into the ED.

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## **17.2 The Challenges of Pediatric Psychiatric Patients in the ED**

The complexities in symptomatology as previously noted pose a challenge for evaluation in the ED, but even “simple” pediatric psychiatric cases place heavy demands on ED staff and resources. The evaluation of children and adolescents can present numerous clinical and safety issues, and differs in multiple ways from a similar evaluation in the adult population [10]. To start, a pediatric psychiatric evaluation must take into account the child’s relationship to the adults in their life. All parties’ contributions to sustaining the child’s problematic behaviors must be ascertained, as well as the contextual forces of community, culture, academic, and home settings. Often times, evaluation must include multiple informants, which involves developing a rapport with various parties, including parents or guardians, extended family members, mental health providers, pediatricians, and teachers. Because children may struggle to express their feelings or thoughts verbally or to provide a linear history of events, the evaluation must take both the developmental appropriateness of the clinical interview and the modality of communication into consideration. For example, younger or severely developmentally delayed children may better provide data through play or drawing, which differs from the expectation of the normal medical interview.

Psychosocial assessment is also more complex for pediatric psychiatric patients than it is for adults. Youth may present with behavioral symptoms that are a reaction to, or manifestation of, psychosocial stress (e.g., a youth acting out in school due to the stress of parental divorce), or psychosocial stress may trigger true psychiatric symptoms (e.g., a youth with depression after the sudden death of a beloved grandparent, or a child with posttraumatic stress disorder symptoms due to abuse at home). Other youth present in psychosocial crisis because a change at home or at school means that their environment is no longer suitable for their care (e.g., a child with autism whose mother becomes ill and is unable to care for them). ED clinicians may struggle to address psychosocial stressors that are not amenable to biological, medical interventions, but are still contributors to the child’s presentation.

Legal and regulatory considerations specific to children and adolescents also make care for children in psychiatric crisis more complicated. Institutional regulations, as well as city or state laws, may affect the way in which emergency psychiatric treatment or hospitalization is carried out. Each state’s statutes have different definitions of what constitutes an acute need for psychiatric hospitalization, as well as varying conceptions of what “voluntary” and “involuntary” care means for minors, who cannot provide legal consent, but may or may not assent to treatment. Clarification of guardianship and consent may be difficult for youth in foster care.

Additionally, clinicians working with this population should be aware of state or city laws that mandate reports of suspected abuse, and whether this pertains to only physical and sexual abuse and neglect, or to other forms of maltreatment as well.

Because of the multiple tiers and modes of information-gathering required to assess children in psychiatric crisis, as well as the complexity of decision-making, assessments of youth in psychiatric crisis in the ED are often lengthy. This is exacerbated by the wait time for consults as well as for disposition planning. EDs typically lack 24/7 access to mental health staff and must wait for the consult team. If admission is recommended, which occurs more frequently for patients presenting with psychiatric concerns than for those with other medical presentations, the wait time for an appropriate (and often rare) psychiatric bed typically leads to youth being held, or “boarded,” in the ED [11]. This, in turn, leads to longer wait times and overcrowding in the ED, so that youth with particularly long boarding stays (often those with the most complex psychopathology and behavioral disturbances) are transitioned to inpatient medical units. At best, these prolonged wait times are unsatisfactory for patients and their families. At worst, extended boarding can contribute to agitation or threatening behavior by patients or family members who have become angry and frustrated over the conditions, crowded spaces, and long delay [12].

EDs have not been resourced to meet the growth in demand for emergency mental health evaluation and treatment, despite the prevalence of the complexities previously noted in this chapter and the burden of care placed on the ED. Nationally, most children with psychiatric complaints are seen in general medical or pediatric EDs, or, more rarely, in psychiatric EDs designed for adults. When youth are seen in medical or pediatric EDs, it is often the medical providers who are tasked with assessing them due to the lack of available mental health specialists. In one study, only 25% of academic medical centers and 8% of community hospitals had child psychiatrists available to evaluate young patients [13]. This indicates a significant barrier for access to appropriate care, as well as an obstacle to carrying out best treatment practices. Bridge and colleagues have reported that nationally, more than half of the youths who presented to EDs for self-injury did not receive any mental health assessment [14]. Pediatricians and emergency medicine physicians are often not trained in mental health assessment, safety planning, de-escalation of agitated youth, or the other parts of evaluation and treatment for youth in psychiatric crisis. Additional staff, such as psychiatric social workers, licensed mental health counselors, and psychiatric nurses, are frequently not available.

In facilities that don’t have a specialized psychiatric emergency room for pediatric patients but that do have one for adults, youth with a psychiatric concern (especially older youth) are frequently seen there; however, adult psychiatrists without specialized training may misinterpret or fail to collect important data in the assessment of youth, especially details related to psychosocial stressors and development. For example, from a developmental standpoint, children are not small adults, so symptoms such as “hearing voices” that mean one thing in adults (i.e., psychosis) often mean something else entirely in young children (e.g., anxiety). Additionally, nursing and support staff in adult psychiatric emergency programs often lack the

expertise required to engage children and adolescents as well as to de-escalate their behavior.

Given these challenges, there are many steps that can be taken to improve the experience of children and families and to reduce the burden on the ED. Determining which steps are appropriate for each individual ED depends on multiple factors, such as the volume of patients seen, available ED resources, and the service system context in which the ED sits. Approaches may include creating services to divert children away from the ED entirely, modifying the physical setting of existing EDs to make them more therapeutic, or creating specialized settings within the EDs themselves. Staffing changes and specialized ED care pathways may also improve the experience of young patients. These different approaches are presented below.

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### 17.3 Making Emergency Services Work for Children in Crisis

Nationally, a majority of youth presenting to the ED with psychiatric complaints are discharged from the ED on the same day they presented [15]. Some research has suggested that a significant proportion of the increase in ED visits for youth is secondary to non-emergent issues related to access or connection to care [16]. Thus, providing other avenues for urgent assessment, and connection to ongoing treatment, has the potential to divert youth in crisis from the ED and reduce unnecessary ED visits.

Mobile crisis programs have been implemented in many states as an attempt to divert patients, including children and adolescents, from the ED [17]. Mobile crisis is a service delivery model that provides rapid response (usually within 1–2 h of referral) and face-to-face stabilization in homes, schools, and community settings. Because of their physical presence in the environment where the event occurs, providers are able to assess contributing contextual factors and can work directly with families, schools, and police, if necessary. After the initial assessment, these programs typically provide connections to ongoing care, and often, they will provide follow-up visits directly for continuous assessment and brief treatment sessions. Mobile crisis programs have demonstrated their potential to increase access to mental health treatment while reducing ED utilization, inpatient hospitalizations, and even arrests and out-of-home placements for youth [17]. In some places, teams even go into EDs to provide psychiatric assessment of patients within the ED if mental health specialists are not available.

Coordination with schools provides another opportunity to direct youth without medical emergencies away from the ED. Many patients referred from schools are, upon assessment in the ED, determined to have non-emergent concerns, though they may require connection to outpatient care for symptoms of ADHD, depression, or anxiety [18]. In-school screening and treatment may reduce unnecessary referrals to the ED. Coordination with schools to encourage the use of urgent-care services instead of the ED can be helpful, especially if this can open the door for connections to ongoing care.

It is also important to reduce the number of repeat ED visits or unnecessary inpatient admissions. Many communities have resources to offer to families to avoid return ED visits, although families are rarely aware of these services. Mobile crisis intervention, in-home family therapy, school-based therapy, parent support groups, and family resource centers can provide key ongoing support for youth and adolescent patients and their guardians. Families presenting to the ED should be given information, when applicable and available, on any local clinics (including those that are school-based or available on a walk-in basis) that offer urgent evaluations. Information should also be given on crisis help lines, suicide hotlines, and crisis text lines that may be available to provide support which can obviate the need for an ED visit.

From a structural perspective, medical EDs can often be dangerous settings for young patients in crisis. Youth who are suicidal or agitated may have access to objects in waiting areas or examination rooms that can be used to harm themselves or others. For example, objects with cords or wires can be used as ligatures, and unsecured equipment such as oxygen tanks can be used as a weapon; the Joint Commission states that all items that can be dangerous and can be removed, must be [19]. EDs are often noisy or crowded, which may further agitate a youth under stress. If youth are placed in an adult psychiatric ED, they can be exposed to a number of adult patients who are severely mentally ill, intoxicated, or agitated, which can create a frightening environment that may be further compounded when staff are not available to speak with, or even provide for, these younger patients in a developmentally appropriate way.

The ideal setting for an emergency evaluation would have youth assessed separately and away from adults in order to maintain safety and provide a therapeutic environment. When possible, grouping older adolescents with one another, or at least separating them spatially from younger children, may also make the milieu safer. Space for private interviews should be available to allow the child and parent to be assessed separately from one another. Patients should be monitored continuously, as well as placed in rooms without sharps or ligature risks. When specialized spaces are not available, many EDs have modified one or two rooms for this use by placing all sharps and ligature risks behind a pull-down, garage-door-style cover that can be locked if the room is being used for psychiatric patients. Other EDs place dangerous objects in locked cabinets. Physical restraints should be located in a secure area that is known and accessible to all staff. The ability to dim lights as well as remove beeping or intrusive equipment (such as vital sign monitors) would also likely help the ED avert some instances of agitation, especially in children with autism spectrum disorder (ASD) or other sensory sensitivities.

Having child-friendly materials on hand can also go a long way to enhance safety and the overall patient experience. Books, toys, and art supplies that can be as simple as markers and paper can entertain children while they wait. For children who are reticent to describe the circumstances of their ED presentation, a provider taking an interest in a shared task, such as drawing, or showing curiosity about a book a child favors, may be able to build invaluable rapport. It is also important to keep items available that address basic human comforts. As reductive as this may seem, having snacks stocked may prove useful in situations that can range from rewarding

a child for utilizing a healthy coping skill to calming a frustrated family (or group of families) waiting for evaluation. Diapers and feminine hygiene products are also necessary. Ensuring that each child has a bed or cot on which they can lie flat to sleep may avert any irritability that can arise from long waits sitting upright in a chair, especially for children who will be boarded overnight.

EDs that tend to experience a very significant volume of child psychiatric patients should consider designating specialized spaces for care of youth in psychiatric crisis, with all of the space modifications noted above. Some EDs will have a wing of their medical or psychiatric ED designated for this population, and staffed separately with child psychiatric specialists. A Children's Comprehensive Psychiatric Emergency Program (such as the one at New York City's Bellevue Hospital) is one version of a specialized child psychiatric emergency program that includes an emergency evaluation area, a brief stabilization unit for inpatient monitoring, and an outpatient crisis clinic for brief follow-up care and bridging [20].

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## 17.4 Staffing the ED to Serve Youth in Psychiatric Crisis

There are only about 8300 child and adolescent psychiatrists practicing in the United States, so children in crisis are often assessed by non-specialized providers (i.e., clinicians or providers who are not child and adolescent psychiatrists) [21]. Pediatricians, emergency medicine physicians, adult psychiatrists, nurse practitioners, social workers, and child life specialists are often called to fill the gap, though they lack training in the emergency psychiatric assessment and treatment of children. Consultation models, including telepsychiatry and virtual distance learning models, are helpful to support clinicians who lack in-depth training in psychiatric care for youth. These consultants may be especially valuable when youth with complex medical and psychiatric needs need to be assessed, or when medical concerns might be the cause of what appears to be a psychiatric complaint (e.g., a child with a history of anxiety that leads to stomachache could also present with appendicitis). Nursing and support staff should be trained to work with children and adolescents, especially in de-escalation and crisis management techniques, to reduce the need for seclusion and restraints. If a crisis intervention is necessary, the staff able to run the psychiatric code should be readily identifiable and familiar with local and hospital policies on restraint or seclusion. Having a physician or nurse on staff who is knowledgeable in the administration of appropriate medications and doses for child and adolescent agitation (which is different from that in adults) is valuable to keep patients safe and avoid iatrogenic harm. A licensed physician must also be available in most states to complete legal paperwork required to authorize psychiatric admission when indicated.

In order to avoid unnecessary psychiatric admissions and boarding, families should be connected to urgent, often intensive, individual and family treatment in the community. Psychiatric social workers and case managers with expertise in the systems of care that serve youth are critical in linking families to these services. Staff should have knowledge of outpatient psychiatric services, family support services, in-home crisis services such as mobile crisis and wraparound services,



therapeutic services and support for youth with autism, and resources in schools. If the child is already receiving services, ED staff should communicate with these providers to obtain the necessary treatment history, communicate risk assessment, and collaborate to determine the patient disposition and to ensure close follow-up.

A psychiatric social worker can also be an important point person when it comes to identifying the signs of child maltreatment, domestic violence, child trafficking, and other concerns; however, all ED clinicians should also be familiar with these presentations. The contact information for local child protective agencies should be made available to all mandated reporters on-site. Some patients or their families may benefit from being given contact information for local legal advocacy groups, whether for educational or housing support, or for protection in cases of domestic violence.

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## 17.5 Caring for Special Populations in the ED

Though every patient deserves person-centered treatment specific to their population of one, it may be useful to consider the specific needs of certain groups of youth that present to the emergency room in crisis. For example, children with autism spectrum disorder may have deficits in their ability to verbally communicate. In addition to moving these youth to less stimulating areas of the ED, multiple modes of approach may be needed to assess and treat their distress, such as communication through the use of pictures or signs, somatosensory interventions that target multiple senses, and implementing contingency management plans such as rewards for safe behaviors [22]. Still, restraints and/or seclusion may be necessary for behaviors that threaten patient and staff safety; therefore, providers should be aware of hospital, local, state, and national guidelines that outline potential risk and the standards of care for these situations [23].

Children who have experienced abuse or trauma of any kind, including medical traumas, may also uniquely struggle to tolerate the ED. Children who are subjects of abuse may visit the ED twice as often as their peers who are not [24], and the ED can be triggering for this group. A trauma-informed approach to care may reduce the overall level of distress experienced by these children and the staff that serve them. The formal definition of trauma-informed approach varies by institution, but generally, it recognizes that trauma is widespread, that it may have myriad effects on patients and staff, that evidence-based treatment should be offered, and that care should be focused on avoiding re-traumatization. Training staff to work with children and families with the assumption that they have likely experienced trauma can be considered a universal precaution, similar to hand washing, and is a safe way to provide care [25].

It is also imperative that ED staff are trained to provide a supportive, affirming experience for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. LGBTQ youth may be two to four times more likely to experience suicidal ideation when compared to their cisgender, heterosexual peers; as a result, it is important to recognize this population when they present to the emergency room so their risk of



harm can be fully appreciated and addressed. Though mandates exist for providers to approach sexual and gender minorities with culturally competent care, many providers still feel undereducated on the topic. This may lead them to avoid asking pertinent questions when a patient presents for care, which then places the burden on the patient to volunteer the information [26]. Experienced staff should also connect these youth to safe spaces and LGBTQ-affirming resources such as clubhouses or specialized psychiatric clinics.

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## 17.6 Summary

This chapter represents ways that emergency psychiatric services can be made more effective and therapeutic for children and adolescents in psychiatric crisis. For a large number of children, the ED is currently serving as a safety net for mental health care because appropriate treatment is not within reach, either geographically or financially. Even for youth living in areas with adequate clinical services and unlimited financial resources, being able to access the right level of care at the right time is challenging. For those living in rural areas without providers, in urban areas where clinics have long wait lists, and those for whom private payment for care is not possible, the ED will remain their only access to the care that they need. Because of this, it is vitally important that EDs implement an internal capability to provide brief assessment, stabilization, and treatment interventions for youth in psychiatric crisis.

Fundamentally, however, the ability to create an emergency mental health system that effectively serves children and families requires an enormous investment that cannot, and should not, be expected to be borne by EDs alone. Education and training programs in emergency medicine, pediatrics, and psychiatry are increasingly recognizing the need for better clinical program development and research in emergency child psychiatry. Technological innovations such as telepsychiatry and virtual distance learning allow for education, consultation, and capacity building to grow across time and space.

Furthermore, national organizations such as the American Association of Emergency Psychiatry, the American Academy of Child and Adolescent Psychiatry, and the Pediatric Emergency Care Applied Research Network continue to highlight the need for standards and resources as well as draw attention to innovative and effective programs. The crisis is ongoing, but there are more ways than ever for providers and systems of care to connect with one another to improve emergency psychiatric care to children and families in need.

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# Special Populations in Psychiatric Emergency Services: The Geriatric Patient

# 18

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## Abstract

This chapter focuses on the geriatric patient with mental illness in the emergency department. As the number of individuals over 65 years of age has increased worldwide, the number of geriatric patients with psychiatric concerns seen in the emergency room has also increased. This chapter discusses the specialized diagnoses that one must consider when evaluating individuals in this population, necessary accommodations for evaluation and treatment, and recommendations for improvements in care delivery for the geriatric patient in the psychiatric emergency arena.

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## 18.1 Introduction

Just as for children, adolescents, and the forensic population, geriatric individuals with emergent psychiatric needs also face a crisis. Complications frequently arise for the geriatric patient cared for in the emergency department (ED), the ED physician, and the medical staff. The geriatric demographic, defined as individuals age 65 or older, represents an increasing proportion of the population. The elderly composed almost 15% of the general population in the United States in 2013 and are expected to increase to over 20% of the population by 2040 [1]. According to a United Nations report, the number of individuals over age 60 has also increased internationally and is expected to comprise over 15% of the global population by 2030 [2]. Elderly individuals exhibit increased emergency department (ED) usage rates compared to younger patients and increased lengths of stay while in the ED [3, 4]. In addition, they demonstrate higher rates of return to the ED, inpatient admissions, and suffer increased morbidity and mortality. Studies in other countries, such as Taiwan [5], Italy [6], Pakistan [7], Turkey [8], and Switzerland [9], show similar increases in visits to the ED by the elderly. Specifically, the elderly accounted for almost one-sixth of all emergency room visits in the United States in the years 2009–2010 [10].

According to data from the Centers for Disease Control and Prevention, and the National Association of Chronic Disease Directors, mental illness occurs in approximately one-fifth of individuals ages 55 and older [11]. The most common psychiatric disorders in this age group are depression, adjustment disorder, psychosis, cognitive disorders, and anxiety disorders [11, 12]. Delirium, a neuropsychiatric emergency, occurs in 8–10% of geriatric patients in the ED [11, 12]; yet, less than 30% of individuals with delirium had mental status examinations documented by the ED physician [13]. Delirium may be the first sign of a medical or surgical emergency, complicate medical treatment, and raise concerns about discharge [14].

This chapter discusses the challenges that complicate the diagnosis and treatment of medical and psychiatric conditions in the geriatric patient and recommends innovations and accommodations to improve the care of this population.

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## 18.2 The Challenges of Older Patients

Older adults in the ED setting require special considerations due to normal physiologic changes of aging. For example, older adults may have chronic deficits in visual sensory input and processing that can limit their ability to navigate a clinical environment; falls and other accidental injuries are a major concern for this age group [15]. Hearing deficits, especially in the absence of appropriate hearing aids, may limit their ability to hear and understand education about illnesses or basic commands. Aphasia or other neurological deficits from prior neurologic insults may limit the capacity to speak or communicate relevant information. The insidious development of a neurocognitive disorder may not be apparent during a cross-sectional interview, and as a result, a progressive, serious illness may not receive

necessary attention and treatment. Lastly, social concerns and the potential for coercion or elder abuse may complicate presentation and management.

The ED environment can also be problematic to the geriatric patient. The unfamiliar environment, frequent examinations by medical personnel, and the absence of familiar faces can increase disorientation in the ill geriatric patient. Further complications requiring clinical interventions may arise after the patient receives “medical clearance” and goes to the specialized psychiatric emergency service (PES). The PES may not allow the use of canes, walkers, or wheelchairs due to the fear that other patients in the facility may use the device as a weapon. Furthermore, the ED or PES may not be handicap accessible.

Often the patient needs to remove assistive hearing devices, eyeglasses, or dental appliances during the medical workup only to find that these items were lost in the hospital transfer process. The loss of hearing aids, eyeglasses, or dentures can affect communication between the patient and family or the patient and physician, and cause confusion in an individual with already impaired cognition. The loss of dental appliances may also affect speech and the ability to eat certain foods. Staff should remember that medications, psychiatric and medical, can lower blood pressure, increase fall potential, and elevate risk of injury to the patient.

Older age frequently carries the burden of multiple medical comorbidities. A given individual may be receiving medicines for hypercholesterolemia, hypertension, diabetes, or other chronic medical conditions in addition to any neuropsychiatric complaint such as insomnia. The ED staff must decipher which of the medications may be exacerbating the presenting problem. Even with electronic medical records, the physician may have difficulty reconciling medications from multiple sources. The evaluation of physical and psychiatric problems, combined with communication difficulties, presents a challenge to any ED staff; studies show that many emergency physicians feel ill-equipped to deal with the geriatric patient [16]. Finally, the severity and number of medical illnesses can result in difficulty with placement as inpatient psychiatric facilities want “medically stable” patients, resulting in problems of boarding where the patient remains in the ED for prolonged periods of time while waiting for an inpatient bed.

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### 18.3 Aggression and Agitation

Aggression and agitation in the elderly are common presenting problems in the ED that may be problematic to the staff. Aggression in the ED or hospital may occur in patients who were, or were not, agitated prior to admission. Not only is the etiology of aggression perplexing, but the presence of aggression raises safety concerns for the staff.

Clinical staff should ascertain the exact signs of agitation and the patient’s baseline status. Agitation may lead to violence toward staff or caregivers. Many individuals (even medical staff) have difficulty dealing with geriatric patients due to misperceptions, prior experiences, patient sensory deficits, and the presence of cognitive disorders in the elderly. These biases, and the fear of violence, make the process of determining the cause and treatment of agitation more difficult. The myriad

diagnoses that could lead to agitation can be perplexing to a clinician. Diagnoses that can cause agitation include medical illness, delirium, pain, dementia with behavioral problems, personality problems, psychosis or mania, and substance abuse. Treatments for all of these conditions are different, and medication actions and interactions can complicate the picture.

Delirium, a common cause of agitation, is a frequent comorbidity to medical illnesses in patients over 65 years [17, 18] and has been shown to be an independent predictor of poor patient prognoses, including mortality, the need for residential placement, and continued decline in cognitive function [19–21]. Delirium often resembles a major neurocognitive disorder and over 60% of incidents of delirium occur in the context of neurocognitive disorder [20]. The only ways to differentiate delirium and major neurocognitive disorder involve careful mental status evaluation, collateral information from individuals familiar with the patient's baseline behavior and cognitive function, and specialized assessment tools. A suspicion of a diagnosis of delirium requires careful diagnostic workup, treatment for the underlying condition, and the provision of appropriate instruction and education to the individuals who assist the patient during their hospital stay and upon discharge.

Neurocognitive disorders, with or without delirium, occur in over one-fourth of elderly patients in the ED, and many cases will go unrecognized [13]. Many of these individuals do not have a cognitive disorder diagnosis prior to the visit [13]. The ED can be frightening to an individual with a cognitive disorder, as they do not understand what is going on. The person may believe that the facility is stealing body parts or involved in another evil endeavor. Confusion can lead to agitation. In turn, ED staff may take less time to understand what is going with the patient due to safety concerns. Evaluation of cognitive disorders is time consuming; one must eliminate medical causes, and treatment options for agitation in delirium may cause even greater problems due to unwanted side effects.

Another cause of agitation or aggression is behavioral manifestations of untreated pain experienced by the patient [22]. Studies show that patients with neurocognitive disorder receiving treatment for pain are less agitated than those who do not receive pain medication [22]. Depression may also be a cause of agitation in the elderly as citalopram, a selective serotonin reuptake inhibitor, has shown to be effective in some studies of agitation [23, 24]. Citalopram may also be effective in treatment of agitation in dementia not related to depression [24].

Substance abuse or withdrawal can cause agitation and should be in the differential for any presenting problem to the psychiatric emergency department. Alcohol and sedative withdrawal can cause delirium tremens, a lethal syndrome [25]. Almost 10% of elderly individuals indicate heavy alcohol use; the use of marijuana in older adults is almost 5% and expected to rise as more states legalize use [26]. Iatrogenic drug use is common in individuals over 65, and physicians frequently prescribe benzodiazepines and opioids for the elderly. The combination can be deadly, and the potential for withdrawal is high [27]. State prescription monitoring programs (PMPs) may be of benefit in helping to detect substance use and misuse. Many states mandate that the prescriber views the PMP record prior to providing prescriptions for controlled substances.

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## 18.4 Depression

Mood disorders, recognized or unrecognized, may be the presenting complaint in the ED for older adults. An older individual may arrive at the ED with symptoms of poor appetite, insomnia, pain, dizziness, or even constipation. Astute questioning may reveal an underlying depression. Due to the higher rates of depression and completed suicide in the elderly population, adequate screening, recognition, and evaluation for psychiatric complaints are a necessity. Untreated depression leads to increased physical morbidity and mortality [28]. Screening tools or questions, such as the Geriatric Depression Scale [17], are helpful in identifying at risk individuals. Due to decreased sensitivity with co-morbid cognitive impairment, medical staff should seek collateral from family or caretakers in order to identify symptoms of depression when the concern arises in these populations.

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## 18.5 Suicidality

Suicidality in the elderly is of particular concern as this population has the highest completed suicide rate; therefore, assessment of suicidality is an important component of the geriatric evaluation by physicians [28]. Risk factors to consider in terms of completed suicide include substance use disorder, medical problems, isolation, impulsiveness, chronic pain, recent stressors, history of completed suicide in the family, older age, Caucasian race, single relationship status, personal history of suicide attempt, and a recent psychiatric hospitalization [29].

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## 18.6 Elder Abuse and Neglect

Chart review and physical examination may indicate that the individual is a victim of abuse or neglect. Concerning factors for abuse or neglect include malnourishment, multiple or unexplained injuries, frequent admissions to the hospital, and non-compliance. Elder abuse occurs in up to 10% of older adults every year [30]. Abuse increases the rate of ED usage, hospitalization, and nursing home admission, and may be the cause of new onset behavioral or psychiatric disorders [30, 31]. In addition, elder abuse may increase risk for psychiatric illness, such as neurocognitive disorders and depression, and contribute to worsening health in general [32].

Elder abuse can range from neglect to psychological, sexual, physical, or financial abuse; the most common types are neglect, psychological abuse, and financial abuse. Comparatively, sexual abuse and physical abuse occur less commonly [30]. The causes for such abuse can be dramatic, such as the attempted expulsion of the abuser from the home by the victim, or a minor disagreement [32]. Ironically, while placing an individual in a nursing home may be the solution in many situations, there is a higher prevalence of elder abuse in the nursing home setting, possibly as high as 25%. Some of the greatest predictors of abuse in a nursing home are the



presence of limitations in activities of daily living (ADLs) and disturbances in a patient's behavior [31].

Elder abuse and neglect represent a challenge in the ED setting as the staff often have limited time and collateral information to investigate such concerns. Additionally, there are often limited resources for social support and rapid placement of potential victims of such abuse [30, 32]. Many times, the safest course of action is to admit the patient for a social admission to prevent further harm. The mandated reporting of elder abuse in most jurisdictions poses an additional burden on ED staff [25].

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## **18.7 Making Emergency Services Work for Geriatric Individuals in Crisis**

Over the past two decades, more research has emerged about what components are necessary to care for the elderly patient in the emergency department. Necessary components include facility design, use of appropriate screening tools, transitions of care, aftercare arrangements, caretaker involvement, and staff training and education. Four US medical organizations (American College of Emergency Physicians, American Geriatric Society, Emergency Nurses Association, and the Society for Academic Emergency Medicine) established guidelines for the care of the geriatric patient in the ED in 2013 [33].

Staff should assess all patients, especially older patients, for mobility concerns at the initial presentation to the ED (triage). Most geriatric individuals merit attention to fall risk due to frailty, medical conditions, prescribed medicines, or substance abuse. The use of wheelchairs, gurneys, and bedside examination equipment can lessen the risk of falls and reduce the confusion that often arises from change in location. For those with intact mobility, adequate lighting and level uncarpeted spaces can help maintain functional status. One study suggested that the use of reclining chairs would cause less distress to older individuals in pain [34]. Staff should minimize the use of restraints. Patients with delirium or a neurocognitive disorder tend to become more confused with restraints as they often do not know what is occurring. Furthermore, restraints can tear already thin skin [35].

Additional environmental intercessions help stimulate cognition and reduce distress. Staff members should provide frequent re-orientation, optimize illumination during the day, minimize noise, reduce staff disruptions and room changes, adjust the room temperature, and provide assistive devices such as hearing aids and glasses. The presence of family members or caretakers is optimal to reduce confusion and provide reorientation [1, 36].

Screening tools are invaluable assets and can elicit diagnoses which would otherwise be missed due to communication barriers. Due to the high risk of delirium associated mortality, screening this patient population will aid in assessment and management. Screening tests include the Confusion Assessment Method (CAM), the Folstein Mini Mental State Examination (MMSE), Brief Mental Status Examination, Delirium Rating Scale (DRS), and Nursing Delirium Screening Scale.

The CAM (which only takes 5 min to administer) is the recommended standardized screening tool for diagnosing delirium in the ED due to the high sensitivity and specificity of the assessment, and the ease of administering it [1, 37, 38]. If the individual has impaired cognition without delirium, dementia is in the differential.

Geriatric patients with a history of substance use disorders may present to the emergency department not only for substance-induced altered mental status, but also for a myriad of physical complaints due to substance use complications. Thus, all patients deserve a careful assessment for substance use. In addition to a careful history and review of medications and pharmacy records (if possible), staff members may utilize screening instruments such as the CAGE (Cut Down, Annoyed, Guilty, Eye-opener) questionnaire, the Alcohol Use Disorders Identification Test-Consumption Questions (AUDIT-C), and the Short Michigan Alcohol Screen Test-Geriatric Version [39, 40].

Other screening assessments include the presence of depression or suicidality [17]. Staff should also screen for falls in the past year, ability to care for self, and presence or absence of social support. The Regional Geriatric Program of Toronto has numerous screening tools, including those mentioned above, available on their website [41].

Not all geriatric patients show the same characteristics. Some individuals who are younger than 60 may have more medical issues than someone who is 80. While medical clearance may not be necessary in the 25-year-old with a history of multiple hospitalizations for schizophrenia, medical clearance is essential in the geriatric patient due to the high incidence of comorbid medical illnesses, use of multiple medications, and drug interactions that mimic psychiatric syndromes. As with all individuals, staff must ascertain the stability of vital signs and physical status. A brief physical exam may highlight possible abuse issues. Routine laboratory studies such as urinalysis, comprehensive metabolic panel, complete blood counts, thyroid functions, electrocardiogram, chest X-ray, vitamin B12, folate, computed tomography scan of the head (if appropriate), and toxicology screens may pinpoint the etiology of delirium. The exam may also highlight ambulation problems that will affect the patient's stay in the ED.

Multiple problems may arise for any patient with transitions in care [42]. For instance, the oncoming shift of healthcare workers may not receive important historical information. The lack of this information, which may not be documented, can cause tremendous harm to anyone. The setting in a busy ED compounds the problems in care transitions given the number of individuals caring for a patient, shift work, and the volume and acuity of patients. An individual of any age who has difficulty communicating needs may be lost in the shuffle of the ED. An individual may leave the psychiatric emergency service (PES) with a prescription for an antibiotic for a urinary tract infection. If the individual lacks resources to buy the medication, the infection could worsen and the individual could become delirious. Other problems that older individuals encounter include difficulty reading or understanding the prescription label, and the inability to open the bottle. Perhaps the individual leaves the hospital with an antidepressant but then develops hypotension, falls, and breaks a hip. Without social support or the ability to reach a phone, the person may

be in pain for a considerable period. These examples highlight the need for defined plans for transitions to care and involvement of the caretaker. Unfortunately, regulations in the United States which require computerized pharmacy printouts of drug medication facts, or lengthy after visit summaries required by electronic medical records, only compound the problem due to the sheer amount of material which is often difficult to comprehend.

The above are recommendations for optimal care of the elderly in the ED. Knowledge of these recommendations can improve outcomes, even in rural emergency rooms without access to a psychiatrist. However, the development of specific geriatric emergency departments designed to address the unique needs of geriatric patients provide solutions to the problems discussed [43]. Ideally, these facilities would utilize a multi-disciplinary approach staffed by geriatric emergency physicians, pharmacists, social workers, case managers, geriatric life specialists or aging-life care specialists, and nurses who specialize in the care of geriatric patients [44]. Appropriate staffing, access to medical services, and access to family are necessary elements for such a unit. In addition, the unit must provide enough personnel and safety measures to monitor for falls and prevent patient danger to self or others. Geriatric patients have been treated in special emergency department settings with some success [35, 45], and specialty units for emergency geriatric psychiatric patients can provide the amenities needed for safe and effective care. When specialist consultation services are not available, telepsychiatry is a viable option to hasten diagnosis and provide effective management [46, 47].

Safety in the patient area is a primary concern. A determined geriatric patient may use tubing, extension and power cords, or intravenous lines in order to make a suicide attempt. Hardware, doors, mirrors, and shower facilities should meet guidelines to lessen the risk of completed suicide [48]. One should not assume that an older suicidal patient poses less risk than a younger individual; geriatric patients often require more vigilance in alleviating all safety risks in patient care areas.

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## 18.8 Training in Geriatric Psychiatry/Medicine

Education and training are invaluable for treating and evaluating geriatric patients in the ED. In the United States, psychiatry residency is a 4-year curriculum approved by the Accreditation Council for Graduate Medical Education (ACGME) that includes a month of geriatric psychiatry. Geriatric psychiatric fellowship is an additional year of training in an accredited geriatric fellowship program. Emergency medicine, internal medicine, and family practice are all 3-year residencies after medical school. After completion of internal medicine or family practice residencies, an individual may choose to enter a 1-year accredited geriatric fellowship in those fields. At this time, geriatrics is not an accredited emergency medicine fellowship, nor is emergency psychiatry an ACGME approved fellowship in psychiatry [49]. Emergency psychiatry is not a requirement of the geriatric psychiatry fellowship. The presence of geriatric specialists in an ED promotes optimal care for this

age range. As mentioned previously, the use of telepsychiatry can provide access to a geriatric psychiatrist if none are available locally [46, 47].

In the United States, geriatric nurses must possess a registered nurse degree and receive either clinical training or advanced education in geriatrics. A geriatric nurse specialist requires a Master's degree and additional specialized training in geriatrics. Case managers and social workers are beneficial to arrange for home health nursing, medication assistance, placement, and supportive care for the caregivers.

The presence of even one of these specialists in an ED that cares for geriatric emergency patients can make a vast difference in care. Specialists provide training for others in the ED and model approaches to take with these patients. Quality improvement and safety initiatives can also provide education and training for the healthcare workers.

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## 18.9 Summary

Psychiatric care of geriatric patients in the ED can be both rewarding and challenging. The interplay of medical and psychiatric issues combined with social issues requires diligence, patience, and investigation. Similar to problems encountered for forensic, child, and adolescent patients, the ED staff benefits from educated staff to provide care for a population desperately in need of their services.

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# Special Populations in Psychiatric Emergency Care: Forensic Patients

# 19

Marc Andrew Colon and Anand Natwarlal Bosmia

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## Abstract

This chapter discusses the challenges posed by forensic patients who present to the emergency room for psychiatric care, and practices designed to improve psychiatric care for these patients. The term “forensic patients” refers to prisoners, jail inmates, probationers, parolees, petitioned patients, patients who have been arrested but not yet undergone the booking process, convicts, and suspects. This chapter also discusses precautions that emergency room personnel should follow when evaluating or prescribing treatment for potentially suicidal forensic patients.

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## 19.1 Introduction

Patients in psychiatric crisis who present to the emergency room from confinement facilities or in the custody of law enforcement are a notable component of the emergency room's patient population. Suicide and violence risk assessments are issues not unique to these patients; however, the evaluation and treatment of forensic patients present various challenges. These challenges include obtaining collateral information about the patient from law enforcement, and determining whether a patient is seeking a specific psychotropic medication for recreational abuse in confinement facilities. Additional challenges include providing safety to healthcare providers, and determining the patient's disposition after evaluation.

At the end of 2016, over 1.5 million prisoners were under the authority of federal and state correctional administrations in the United States [1]. As of midyear 2016, over 700,000 inmates were confined in city and county jails in the United States [2]. A significant percentage of inmates in jail and prison have mental illness [3, 4]. More than 350,000 seriously mentally ill individuals are incarcerated in the United States [5].

Deinstitutionalization, a policy that involved the reduction of beds available at state psychiatric facilities, has made emergency rooms in the community a source of treatment for persons who have chronic mental illness [6]. Many chronically mentally ill patients who were released into the community secondary to deinstitutionalization ended up homeless because of the severity of their illness, lack of social support, and lack of less restrictive psychiatric facilities such as group homes. Poor social support and noncompliance with follow-up care place chronically mentally ill persons at greater risk for engaging in criminal behavior. A 4-year-long study evaluating prisoners released from state prison in Utah found that the median time to return to prison was 743 days for prisoners without serious mental illness, and 385 days for those who were seriously mentally ill [7].

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## 19.2 Definitions of Confinement Facilities and Forensic Patients

Emergency room personnel should know the differences among the four types of confinement facilities in the United States, which are lockups, jails, prisons, and supermax facilities; the most common type being a lockup [8]. A lockup, which is also known as a "drunk tank" or "holding tank," is authorized to hold people before arraignment for up to 48 h, and local law enforcement officials administer most lockups [9]. Local law enforcement officials also operate jails, which confine a person before or after adjudication, or confine a person who is sentenced to a period of incarceration of 1 year or less [8]. A prison has custodial authority of a person sentenced to a period of incarceration of more than 1 year [8]. A state correctional department or the Federal Bureau of Prisons operates a prison [8, 10]. A supermax facility or security housing unit is a freestanding facility (e.g., a federal



prison) or a distinct unit within such a freestanding facility, which manages seriously disruptive or violent offenders [8]. Of note, jails may hold mentally ill individuals before those individuals are moved to a facility for psychiatric care [8], and jails may hold individuals awaiting trial, sentencing, or transfer to another facility after conviction [11].

Emergency room personnel should also know the difference between probationers and parolees. A court of law places probationers under adult supervision in the community, usually as a substitute for incarceration [12]. Probationers may serve a split sentence, which involves a short term of incarceration followed immediately by probation [12]. Active probation mandates that a probationer report to a probation officer at regular intervals, whereas inactive probation does not require a probationer to report to a probation officer [12]. Parole is a conditional release from prison and involves placement of the offender under adult supervision in the community [13]. A parole board may decide to place an offender on parole at its discretion, or in accordance with a statute's provisions [13].

Petitioned patients are patients who are brought to the emergency room involuntarily, under an emergency petition filed by law enforcement or other concerned parties such as the patient's family or treating physician, on the grounds that the patient is an acute danger to himself, an acute danger to others, or gravely disabled. Most states have statutes that permit law enforcement officials to place individuals requiring emergency psychiatric intervention under an emergency petition [6]. Specific guidelines on how to obtain an emergency petition and who can sign an emergency petition vary from state to state [6]; therefore, emergency room personnel should know their state's mental health statutes [14]. Clinicians evaluating petitioned patients should consider the following questions in their psychosocial assessment of these patients:

1. What is the reason for the emergency petition?
2. Does the patient meet the legal criteria for an involuntary hold?
3. Did the family or legal authorities obtain the legal petition?
4. Who transported the patient to the emergency room?
5. Does the patient abuse alcohol or illicit drugs?
6. Does the patient have a history of criminal behavior? [6].

A patient can have just been arrested but not yet undergone the formal booking process at a lockup. This type of forensic patient is the "arrested-but-not-yet-booked" patient. Even though the patient has not undergone the booking process, the patient is still in the custody of law enforcement. Finally, emergency room personnel should know the difference between criminals and suspects. A criminal is a person who has been convicted of a crime, whereas a suspect is a person who is thought to have committed a crime [15]. A person in the custody of law enforcement is not necessarily a criminal, as he may not yet have been convicted of a crime. Conversely, a criminal may not be a jail inmate or prisoner because he has served his sentence and is now released into the community.

### 19.3 Psychiatric Decompensation in Forensic Patients

The 2011–2012 National Inmate Survey (NIS-3) used the Kessler 6 Nonspecific Psychological Distress Scale to assess the prevalence of serious psychological distress in the 30 days preceding the survey, and to estimate the percentage of inmates ever diagnosed by a mental health professional with a mental illness [16]. The percentage of inmates who had experienced serious psychological distress in the 30 days preceding the survey was greater for jail inmates than for prisoners [16]. Jail inmates reported prior diagnoses of major depressive disorder, bipolar disorder, anxiety disorder, and post-traumatic stress disorder [16]. Prisoners reported prior diagnoses of major depressive disorder, bipolar disorder, borderline or antisocial personality disorder, post-traumatic stress disorder, and schizophrenia or another psychotic disorder [16].

Persons may enter a confinement facility without a formal psychiatric diagnosis but later develop a primary psychiatric illness while incarcerated. Inmates with chronic mental illness may present from a confinement facility if their psychiatric decompensation is severe enough to warrant observation in an emergency room, or admission to an acute inpatient psychiatric unit. Healthcare providers must determine whether or not the patient's alleged criminal behavior is due to a psychiatric disorder requiring immediate treatment [6].

Individuals who have spent a considerable length of time in prison and have recently been released on probation or parole can engage in maladaptive behavior because they are not adequately socialized. Some of these individuals may be “institutionalized” and have difficulty living in a community setting without the structure of a confinement facility. Probationers and parolees brought involuntarily to the emergency room by law enforcement may fear that they will have to return to a confinement facility because they violated the terms of the probation and parole by engaging in illicit activities such as drug use.

The “arrested-but-not-yet-booked” patient or suspect, while in route to a lockup or jail, may verbalize suicidal or homicidal ideation, or exhibit behavior that law enforcement officials deem warrants a psychiatric evaluation. Clinicians must determine whether these patients are actually experiencing psychiatric illness or malingering, a task which can be challenging. The “arrested-but-not-yet-booked” patient or suspect may seek admission to a hospital for various reasons: to avoid the less comfortable setting of a confinement facility; to increase chances of escape, as a hospital is less secure than a confinement facility; or to avoid the legal proceedings against them [17]. Prisoners and jail inmates also may feign psychiatric symptoms for these reasons, or to obtain psychotropic medications for recreational abuse [17].

Healthcare providers should suspect sexual victimization in depressed jail inmates and prisoners. Both victims and perpetrators of inmate-on-inmate sexual victimization tend to be males between the ages of 25 and 39 [9]. Men who attempt or achieve sexual violence tend to have convictions for juvenile robbery and adult sexual assault, and have been imprisoned longer than prisoners who do not perpetrate sexual assault [9]. Prisoners who are victims of sexual assault tend to have one

or more of the following traits: first-time offenders with no history of violence, physical weakness, convicted of a crime against a minor, viewed as effeminate by other prisoners, not affiliated with a prison gang, or thought by other prisoners to have cooperated with law enforcement [9].

Healthcare providers must determine whether the patient's psychiatric decompensation is caused by a primary psychiatric illness or a non-psychiatric problem. Delirium should be on the differential when an agitated forensic patient presents to the emergency room. Drug consumption and substance withdrawal can cause delirium [18]. An analysis of the Arrestee Drug Abuse Monitoring (ADAM) Program revealed that less than 30% of jail administrators reported that alcohol or drug detoxification services were provided at their jails [19]. Thus, emergency room personnel must obtain a detailed history of any substance abuse by the forensic patient.

Psychiatric decompensation can result from poor management of chronic medical problems. Examples of chronic medical problems found among jail inmates and prisoners are HIV, hepatitis C, hepatitis B, tuberculosis, and hypertension [20]. The most common chronic medical problem reported by jail inmates and prisoners is hypertension [20]. Hypertensive crisis, hepatic encephalopathy, and opportunistic infections in the setting of AIDS are potential causes of psychiatric decompensation in forensic patients. Emergency room personnel must obtain a detailed history of the patient's medical problems and a list of the patient's current medications to determine whether an acute and reversible medical problem is causing the patient's psychiatric decompensation.

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## 19.4 Recreational Abuse of Psychotropic Medications

Substance abuse is the most common diagnosis in both female and male offenders in a correctional setting [8]. At the time of entry into a correctional facility, more than two-thirds of individuals meet the criteria for a substance use disorder [21]; and the fourth most frequent cause of death in jails is drug or alcohol intoxication [22]. Incarcerated individuals use psychotropic medications recreationally. Forensic patients who abuse substances or divert psychotropic medications for personal gain may insist on obtaining specific psychotropic medications. Clinicians must consider the possibility of abuse or diversion whenever a patient focuses on obtaining a specific psychotropic medication and insists that no other medication will work.

Studies from correctional facilities nationwide identified the most common psychotropic medications that inmates abuse or barter [23]. Quetiapine is a second-generation antipsychotic that is crushed into a powder and snorted, or administered intravenously for sedation and anxiolysis [23]. Antidepressants abused for their sedative effects include amitriptyline and paroxetine [24]. Intranasal bupropion is abused for its euphoric effects [24]. Thus, emergency room personnel must know which psychotropic medications are drugs of abuse in confinement facilities.

## 19.5 Forensic Patients, Suicide Risk, and Violence Risk

Self-harm and suicide are more common among prisoners than the general population [25]. Suicide is the fifth leading cause of death in prisons, and the leading cause of death in jails in the United States [22]. Violence is common in many confinement facilities [25], so a detailed psychosocial evaluation is critical for assessing a forensic patient's risk for suicide or violence. Suicides occur in lockups at much greater rates than suicides in jails or prisons [8]. Lockups are less likely to have protocols for monitoring an inmate for suicide risk; lockups often do not have a qualified mental healthcare provider [26]. As a result, the type of confinement facility from which a forensic patient presents is pertinent when assessing the patient's risk for suicide.

Risk factors for suicide in forensic patients are active suicidal ideation, occupancy of a single cell, history of attempted suicide, history of psychiatric illness or use of psychotropic medication, history of contact with mental health services, history of substance abuse, and being married prior to incarceration [25]. Cognitive deficits should also be included as potential predictors of suicidal acts [27]. There is an elevated risk for suicide during the first 24–48 h of confinement and close proximity to court proceedings [28]. A study compared the characteristics of inmates who completed suicide (completers) to those of inmates who attempted, but did not complete, suicide (attempters) [29]. According to this study, completers tended to be male, older, more educated, and married, separated, or divorced, awaiting trial, charged with violent offenses, confined in jail, confined to a single cell, housed in an inpatient mental health unit or protective custody setting, and not on suicide watch [29]. Additionally, completers tended to have been under close observation previously, were more likely to attempt suicide at night, and committed suicide by hanging [29].

Emergency room personnel must specify suicide precautions for a forensic patient who has multiple risk factors for suicide. These precautions must include instructions forbidding the patient to have sheets or shoelaces in his cell which the patient could use to hang himself and forbidding the patient to use eating utensils which the patient could use to stab himself at the site of a major vein or artery. If, after speaking with the confinement facility's staff, the psychiatrist determines that neither the patient's safety nor follow-up care can be ensured, the patient should be admitted for further observation and treatment [17]. It is the responsibility of the emergency room physician to ascertain and document the ability of the confinement facility to provide adequate precautions for the discharged forensic patient.

Forensic patients with a history of violence should be approached with extreme caution in the emergency room. Emergency room personnel must provide for the safety of all parties involved in the care of a violent or potentially violent patient before initiating treatment [15]. Risk factors for violence include younger age, membership to an ethnic minority, low level of education, affiliation with a gang, and prior diagnosis of major mental illness [25]. Forensic patients who are gang members are especially dangerous, as gang members will not hesitate to injure or kill a person thought to have disrespected them [30]. Emergency room personnel

must review any paperwork provided by law enforcement that details the patient's violent behavior, and obtain collateral information from law enforcement to clarify whether the patient has a history of violence.

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## 19.6 Cooperating with Law Enforcement

Emergency room personnel must collaborate with law enforcement officials who bring patients to the emergency room for a psychiatric evaluation. Law enforcement officials present in the emergency room can include members of the hospital's security staff, and personnel affiliated with government agencies [15]. These professionals are essential to the management and care of uncooperative or violent patients, and they assist emergency room personnel by restraining combative patients, detaining patients who lack decision-making capacity and attempt to elope, and securing weapons brought by patients into the emergency room [15]. It should be noted, however, that the presence of law enforcement in the emergency room can conflict with healthcare providers' moral duty to respect forensic patients' confidentiality and physical privacy [31].

Per the American College of Emergency Physicians, law enforcement may need to be present to ensure the safety of both the patient and hospital staff, even without consent from the patient [32]. When the presence of law enforcement is deemed necessary during the psychiatric evaluation of a potentially violent forensic patient, the law enforcement official should be of the same sex as the patient, and if a law enforcement official of the same sex is not available, a chaperone of the same sex should be present [15]. The American College of Emergency Physicians holds that emergency room physicians should obey state and federal laws regarding confidentiality and privacy [32]. Law enforcement may need to be present within earshot of the patient if the patient is at high risk for behaving violently. Otherwise, law enforcement should only be privy to the interaction between the patient and the patient's healthcare providers with the patient's explicit consent [15].

Law enforcement has played a greater role in managing persons experiencing psychiatric emergencies since chronically mentally ill patients were released into the community following deinstitutionalization, and the police are very often the first professionals called to manage persons experiencing psychiatric emergencies [33]. Police in all 50 states are authorized to bring individuals whom they consider to be acutely dangerous because of mental illness, either to themselves or others, for psychiatric evaluation and treatment [33]. Police have a responsibility to recognize a mentally ill person's need for treatment, or determine that the person's criminal act and arrest are the primary concerns [33]. This task is difficult, and law enforcement officials can receive additional training in recognizing persons who are experiencing a psychiatric crisis, and in deescalating the situation. Crisis Intervention Team (CIT) programs offer this kind of training.

The first CIT program was established in Memphis, Tennessee in 1988 [34], so it is therefore known as the Memphis model [33]. CITs are police units consisting of uniformed officers specially trained in handling persons experiencing psychiatric

emergencies [35, 36]. When dispatchers receive a call involving a person experiencing a psychiatric emergency, a CIT officer is sent to the scene [34]. In the 4 years following the program's establishment in Memphis, the rate at which law enforcement brought persons to the emergency room for a psychiatric evaluation doubled in the city [35]. Emergency room personnel must know whether CIT programs are active in their area of practice; the Memphis model relies heavily on close cooperation between law enforcement and hospitals whose administrative officials have agreed not to refuse any person brought by law enforcement for psychiatric evaluation and treatment [33] (see Chap. 6 for additional information).

Emergency room personnel must be diligent in their efforts to obtain collateral information from the law enforcement personnel involved in bringing a patient for a psychiatric evaluation. The patient's past contacts with law enforcement when psychiatric illness was thought to be present, the patient's actions during those contacts (such as suicide attempts and violent behavior), and the means by which those contacts were resolved [33] are critical factors in determining the patient's disposition. Emergency room personnel may not be able to obtain collateral information from associates, friends, or family of a patient who is in the custody of law enforcement, because doing so may alert those persons as to the patient's whereabouts and prompt them to help the patient escape custody. For this reason, emergency room personnel must know their hospital's policy regarding obtaining collateral information from the family or friends of a patient who is in the custody of law enforcement.

Communication between the psychiatrist and officials representing the confinement facility is important in planning the forensic patient's disposition. Clinicians should inquire about treatment and observation options at the specific confinement facility and, in the event that the patient is discharged to that facility, inform the facility's staff about the patient's assessment and recommended treatment plan [17]. Some confinement facilities may have a psychiatrist or other mental health professional readily available to manage a patient's psychiatric medications. Other confinement facilities may not have such a specialized professional and rely instead on primary care physicians to manage a patient's psychiatric medications.

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## 19.7 Summary

Emergency room personnel will encounter forensic patients who present for a psychiatric evaluation. Knowledge of the specific type of confinement facility from which the patient presented and the patient's current arrest status are critical components of the psychosocial evaluation of forensic patients. Emergency room personnel must familiarize themselves with the confinement facilities in their local area, the extent of mental health services that those facilities provide, and the commitment laws of their state of practice. Emergency room physicians should also know what type of care the correctional facility provides for suicidal patients, including the availability of follow-up mental healthcare and the ability to provide strict precautions to ensure that suicidal patients do not attempt, or complete, suicide. Additionally, clinicians should be aware that there are various psychotropic

medications used recreationally or as barter among inmates and prisoners. Cooperating with law enforcement is essential, as law enforcement officials are an invaluable source of collateral information that helps clinicians formulate a treatment plan for the forensic patient. Emergency room personnel must respect the forensic patient's rights to physical privacy and confidentiality unless circumstances warrant making these rights subordinate to the safety of emergency room personnel, law enforcement officials, and the patient.

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## **Part III**

# **Selected International Models of Psychiatric Emergency Care**



# International Models of Psychiatric Emergency Care: Canada

# 20

Bruce Fage and Jodi Lofchy

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## Abstract

This chapter reviews the current state of emergency psychiatry in Canada, a large and geographically diverse nation with population centers spread across thousands of kilometers. Topics include health care funding models, emergency psychiatric service structure, and typical patient flow in the emergency setting. The authors explore clinically significant variations in mental health legislation and national training approaches to emergency psychiatry.

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## 20.1 Introduction

As a large and geographically diverse nation, Canada's relatively small population of approximately 37 million people is divided between 10 provinces and 3 territories, with most living in or near a population-dense urban center. With an area of almost 10 million square kilometers, there are great distances between major centers [1]. Up to 20% of the population lives in rural and remote communities with variable access to resources. A recurring challenge within the Canadian health care system is ensuring access to consistent, quality health care for all citizens, regardless of geographic location.

According to the United Nations Human Development Index, Canada is a very highly developed country and its citizens enjoy a high level of education, long and healthy lifespans, and a high standard of living [2]. The average age is increasing, with the proportion of seniors steadily rising over the past 50 years. As the rate of natural increase (births compared to deaths) declines, immigration accounts for almost two-thirds of the population growth rate, which amounted to 257,900 new Canadians in 2012 [3].

Canada has two official languages, English and French, with approximately 58% of the population speaking only English at home, 18.2% speaking only French at home, and the remainder speaking a mix of English, French, or multiple nonofficial languages. Approximately 6% of the population does not speak either English or French at home. The majority of the French-speaking population resides in Quebec, the second-largest province by population. In 2011, approximately 1.2 million (4.3%) people in Canada's population have an Aboriginal identity, a broad term that encompasses many cultural groups including First Nations, Inuit, and Metis peoples [3].

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## 20.2 Emergency Psychiatry Service Structure

The structure of emergency psychiatry services varies widely across the country. Urban, academic, and high-volume centers are more likely to have designated spaces for emergency psychiatric assessments. Rural or community settings may still have the psychiatrist as a consultant, assessing patients in an interview room or by the bedside in the local hospital emergency department; in rural and remote communities, patients may also need to be transferred great distances for a psychiatric assessment [4]. In some provinces, there is some movement toward using telepsychiatry in the emergency setting to improve access for remote patients, though this is currently in early stages and not widely or routinely utilized.

Experts acknowledge that the evaluation of patients suffering a psychiatric crisis must occur in an environment that fosters patient and staff safety. If a patient with a mental health crisis is seen in a general hospital, staff should ensure that the assessment is in a secure spot, specifically designated for such individuals who are identified at triage [5]. This model allows the emergency physician to initially screen for acute medical problems that may be contributing to the presentation. The emergency physician also has the ability to manage less urgent cases, perhaps

involving a crisis clinician (typically a nurse, psychologist, or social worker with training in providing psychosocial support) or member of the psychiatry team, thereby avoiding the need for an emergency psychiatry referral. The setting for emergency psychiatric evaluation should have laboratory facilities available on site, easy access to investigations such as bloodwork and imaging, and medical or surgical consultants nearby.

Outside the general hospital, emergency psychiatric care may be accessed from psychiatric hospital emergency departments. Some of these hospitals provide 24/7 emergency care. Although these hospitals may be less likely to have on-site lab facilities and medical support, they are staffed by psychiatric care specialists who can knowledgeably and empathically assess and treat those in crisis. Psychiatric hospital settings will typically have access to a broader array of both inpatient and outpatient resources as disposition alternatives.

Hospitals across the country are moving to a model of best practice in emergency psychiatry with the creation of holding units in the emergency setting. The use of observation beds benefits many patients; extended observation provides a longer period for evaluation and offers treatment to recover from a crisis while removing the necessity for inpatient admissions [5]. Holding units benefit patients suffering from substance-induced states, as their symptoms will usually remit as the toxidrome resolves. Holding units are typically locked and either embedded directly into the main emergency department or in close proximity. Unlike the United States, not all holding units are capped at a maximal time for stay in the unit. Ideally, the length of stay is meant to be less than the length of time of the initial involuntary hold (usually 72 h in most provinces). Admission status varies dependent on hospital policy—some units require the patient to be admitted to the hospital but located in the short-stay emergency unit, others have the patient held for an extended assessment under the care of the emergency psychiatrist.

When no psychiatry holding unit exists, patients are usually evaluated in the general emergency department, and, if admission is required, the individual must wait there until a bed is available at a psychiatric unit or facility. These patients become Admit No Bed (ANB) patients and treatment begins in the emergency department while awaiting a bed; this status may be suboptimal if there are additional resources available through the inpatient unit that are not available in the emergency department. Ultimately, holding unit or not, the limiting factor for admission to the psychiatry unit is the length of stay on the inpatient unit, and access to available beds.

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## 20.3 Emergency Psychiatry Service Systems Flow

The vast majority of emergency psychiatry service encounters begin with registration and triage by an emergency department nurse, who will assign a Canadian Triage and Acuity Scale (CTAS) score. This score is based on clinical findings and used to indicate level of acuity and time the patient should wait to see a provider, ranging from level 1 (resuscitation, 0 min) to level 5 (nonurgent, 120 min) [6]. The triage nurse will record a presenting complaint and, where applicable, triage to the

appropriate section of the emergency department. From a psychiatric perspective, there is a range of scores available depending on presentation. Acute psychosis or extreme agitation is considered level 2 (emergency, to be seen within 15 min), whereas depression or suicidal thinking may be level 4 (less urgent or semiurgent, to be seen within 60 min) [7]. Though these are targets, the actual time to assessment will be highly variable and based primarily on the emergency department's volume and resources. While there have been suggestions that patients with mental health concerns may wait longer than those with physical health concerns, data from Ontario suggest that patients with mental health concerns actually wait less for physician assessment when the emergency department is crowded and only slightly longer when it is not crowded [8].

After triage, the patient will be assessed by an emergency nurse who, depending on that hospital's model of care, may or may not have specialized training in psychiatric nursing. The emergency nurse will take a preliminary history and conduct investigations as ordered by the emergency physician. Working as a team, the psychiatric or general emergency nurse and physician will perform a history and physical examination of the patient, order and interpret laboratory values, make preliminary and differential diagnoses, and determine initial management. The emergency physician might involve available allied health workers, including social workers and crisis clinicians, to concurrently assess the patient and provide additional resources and crisis support. The majority of patients presenting with a mental health or addiction concern are managed by the emergency physician and team and do not necessarily require referral for an emergency psychiatric consultation. In these cases, the emergency team could make use of a patient's existing supports or link them to an urgent care program. In academic or high-volume centers, tensions can arise around suitability or timing of referral; for instance, a patient who is intoxicated and expressing suicidal ideation may not be suitable for psychiatric assessment and would need time to clear in the emergency department. There are often disagreements over the definition of an adequate medical examination of the psychiatric patient, the role of laboratory testing and urine drug screening, and the capability of the receiving psychiatric facility or unit to manage concurrent medical acuity [9]. Ultimately, teams must work to support each other and understand their respective concerns in order to provide optimal patient care as volumes increase. Settings with integrated emergency holding units note a more collegial and respectful working relationship between the emergency and psychiatry teams. There is some evidence to suggest that psychiatric emergency service utilization in Canada is increasing over time, but this could be due to population fluctuation [10].

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## **20.4 Personnel and Staffing: The Psychiatric Emergency Services Team**

Although the team composition varies among provinces, the differences between urban and rural or remote settings is much greater, mostly related to the availability of resources. Regardless of the setting, the team composition within psychiatric emergency services is likely similar.

Teams may include psychiatrists and, in academic centers, resident doctors undertaking training to be specialists in psychiatry, family medicine, or emergency medicine. Teams also include psychiatric nurses, social workers, and orderlies (sometimes called psychiatric or patient assistants). Security professionals play a key supporting role and may be located within the psychiatric unit or space, or in an area with close access.

The role of the team is to comprehensively assess the emergency crisis, make a biopsychosocial diagnosis of the situation, treat acute distress or symptoms, and proceed to appropriate intervention. The emergency assessment is not complete without linking back to the community treating physician or team, and including family or significant others in both the assessment and disposition phases. Often, the underlying psychopathology that has contributed to the crisis cannot be fully addressed at the point of emergency contact, but a plan can be developed to reduce some of the acute distress and guide future treatment.

A psychiatric or general emergency nurse will proceed to pre-evaluation of the patient and participate in data collection and interventions. A social worker may work to identify social problems and determine any need for support or protection for the patient and their relatives. A social worker typically establishes contact with relatives, caretakers, or an outpatient treatment team to obtain collateral history (with respect to confidentiality limits). In most jurisdictions, providers in the emergency setting are allowed to contact friends and family members to obtain collateral information; otherwise, information is usually not allowed to be shared outside of a basic update (e.g., “the patient is medically stable”). While the details and exact requirements vary between the provinces and territories, there will also be mandatory reporting requirements the emergency psychiatry services team members must follow, particularly with respect to suspected child abuse or neglect, or if a patient is experiencing a condition that may affect their ability to safely drive.

Psychiatrists and resident doctors will assess medical conditions, including physical as well as psychiatric components, and collaborate with the emergency department physician. These actions can all take place concurrently, and the team will strive to effectively share information in order to make a diagnosis and treatment plan. Treatment might include medical, pharmacological, psychological–systemic–familial, and social interventions conducted by one or more professionals, depending on required expertise and critical issues. Some teams may access subspecialized addiction support including addiction nurses or physicians. These teams can provide more specific interventions for patients with substance use disorders, like motivational interviewing, referral to transition beds for withdrawal or respite, or longer term substance abuse treatment programs. When available, there are varying levels of addictions integration into emergency services.

Emergency psychiatry services often work closely with law enforcement. The police may bring patients for emergency psychiatric assessment, whether they are called by the patients themselves, their relatives or caretakers, or outpatient services. Sometimes, police are required to execute court orders (e.g., patients under court authorization for treatment who did not present for treatment injections or

follow-up appointments; or admitted patients who absconded from the hospital illegally). When this happens, the police description of patients' behavior is often clinically relevant and helpful to the emergency team. Working with the police presents opportunities for ongoing education regarding the identification of those with mental illness and approaches to interaction when apprehending an unwell patient. New initiatives like the Mobile Crisis Intervention Teams (MCIT) bring nurses and police together in the community to respond to emergency calls when a mental health issue is suspected.

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## 20.5 Considerations of Coordination of Care

A range of dispositional options are essential to a functional emergency psychiatry service. Many inpatient admissions can be avoided with the option of timely crisis follow-up from the emergency department, preferably with members of the emergency psychiatry team. Follow-up options range from community follow-up with the family physician for less urgent cases to specialized psychiatric crisis clinics where patients are ideally seen within less than a week.

Key community partners in providing care to the emergency psychiatry population include addiction resources such as treatment programs and detox centers, shelters, crisis residential housing, mobile crisis teams, and children's aid services. At times, these partners will attend the patient in the emergency department to liaise and facilitate transfer. More commonly, a taxi or public transportation is provided at the time of discharge to ensure the patient arrives as planned at the receiving facility.

A number of the more chronically ill patients have case managers in the community and are a part of Assertive Community Treatment teams (ACT). These multidisciplinary teams are intended to support patients with severe and persistent mental illness who have complex service needs, have not been successfully supported by lower intensity teams, and have frequent or extensive use of psychiatric admissions [11]. The case manager or team member will provide valuable information to the emergency team with respect to the patient's recent functional status, and will work together with the team to ensure the patient is safe for discharge. ACT team members may attend the emergency department to assist in the assessment of their patients, which allows for valuable collateral information that may help determine whether a patient requires admission. In cases where these patients have complex medical and psychiatric problems, their emergency needs may be best served in a general hospital setting with easy access to both services.

Models of crisis clinic follow-up vary depending on the hospital resources available. Not all hospitals across the country have access to this important aspect of emergency care. Crisis clinics are often staffed primarily by nonphysicians—psychologists, social workers, or occupational therapists—except, perhaps, for a psychiatrist overseeing the clinic who is also available to see patients as needed. At

times, psychiatric nurses with some therapy training are involved in crisis follow-up. Other clinics integrate the psychiatrist directly into the clinic to see select patients for either diagnostic or medication assessment. Patients can be followed in these clinics for a number of sessions (the range varies, but typically less than 20 sessions, and more commonly less than 10 sessions). The goal is to reintegrate the patient back into the community and to work with primary care teams to develop a smooth transition to outpatient care.

There is growing research that suggests a need for more outpatient psychiatric supports in Canada, and anecdotally, wait times for outpatient assessments may be several months depending on local access. Among youth in Ontario, there was a 32.5% increase in mental health-related emergency department visits between 2006 and 2011, but only a 15.8% relative increase in outpatient visits [12]. Though unclear, it is possible that the increase in emergency department utilization reflects difficulty accessing outpatient psychiatric supports, necessitating a need to return to the emergency department. Outpatient follow-up after discharge is associated with a reduction in rehospitalization [13]. At the Centre for Addiction and Mental Health (CAMH), Canada's largest academic psychiatric hospital, a bridging clinic model of care has recently been implemented to provide faster access for patients recently discharged from an inpatient unit or the CAMH emergency department. With this approach, patients can access psychiatrists and crisis clinicians through a drop-in model using a patient-centered structure and negating the need to follow-up at a specific date and time. Canadian institutions continue to explore models of care that provide high quality, timely access for patients across the country.

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## 20.6 Health Care Funding and Resources

To appreciate models of emergency psychiatric care in Canada, it is critical to understand the basic principles that underpin the delivery of health services. Canada's health care system is defined by the Canada Health Act, which aims to promote the physical and mental well-being of Canadian residents, and facilitate access to care without financial barriers [14]. Through 13 provincial and territorial health insurance plans, the system aims to provide comprehensive access to health services without direct charges at the point of service. Though the provincial and territorial governments are responsible for the administration and delivery of health services, the federal government sets national standards through the Canada Health Act and provides funding support to provinces and territories through the Canada Health Transfer. In effect, the Canada Health Transfer is a redistribution of funding between provinces and territories by the Federal government that strives to avoid shortfalls by ensuring long-term funding predictability [14].

Provincial and territorial health insurance plans must meet standards in five areas in transfer payment funding from the Federal government to the provinces and territories. The health plans must be publicly administered and not for profit; they must cover all medically necessary services provided by doctors and hospitals; plans



must cover everyone while in the home province and during travel to another province or territory, and all residents must have reasonable access to care [14].

While a full discussion of all physician and hospital funding models in Canada is beyond the scope of this chapter, a brief overview is needed to provide an understanding of how interprofessional teams function within the system. Most physicians operate primarily on a fee-for-service basis, billing the provincial and territorial government insurance plans directly for the services they provide. The billing codes are standardized for each province and territory, and typically set through a negotiations process between the provincial and territorial medical associations and the provincial Ministry of Health. Thus, though the physician does not get to set the rate that they wish to charge for their services, the insurance plans will reimburse services in a reliable manner provided the patient is eligible for coverage. Physicians are typically not employees of a hospital, though they may obtain privileges to practice in one. Hospitals are primarily funded by the provincial and territorial governments, which include money for human resources, infrastructure, and medical supplies [14].

Because coverage is universal, there is no discussion regarding in or out of network hospitals or providers, and any patient who arrives at a hospital will be treated. Some hospitals will serve a catchment area, meaning they preferentially accept referrals for patients living in a certain geographical area that they serve, though this is typically more relevant for ambulatory services. Notably, while hospital services and outpatient visits to a specialist or family physician are covered, there is no universal pharmaceutical coverage program. Although seniors and persons on social assistance may qualify for prescription drug coverage, many Canadians do not have access to a consistent prescription drug plan.

At the point of emergency care, although most patients who present to the emergency department would have coverage through their provincial or territorial insurance plan, they may not have their health card or be forthcoming with personal information. The patient would typically be registered with as much information as possible, and efforts would be made by the team to find their legal identity. It should be noted that there is a 3-month waiting period for most health insurance plans for newcomers to Canada, though the Interim Federal Health Program provides temporary health insurance for refugees and refugee claimants [15].

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## 20.7 Mental Health Legislation

Emergency psychiatrists in Canada routinely make decisions about involuntary hospitalization and treatment. As a result of increasing patient volumes and the number of patients who are admitted to the hospital with no bed, the likelihood that a psychiatric patient would be managed by a psychiatrist in the emergency department is high. All provinces and territories in Canada have mental health-related legislation that sets direction around the ability to involuntarily detain and treat people experiencing mental health crises. However, there are clinically significant differences in

Canadian mental health acts between jurisdictions that impact the physician's ability to provide treatment [16]. With respect to involuntary admission, all provinces and territories require that the patient must meet the definition of a mental disorder; though this definition may be broad (e.g., Ontario defines this as "any disease or disability of the mind"). All jurisdictions require that the individual be likely to cause harm, though the type of harm is quite variable. In Ontario and the three northern territories, harm must be bodily, including harm to self, others, or substantial physical impairment; specifically, this does not include mental deterioration or psychological harm. Individuals who are experiencing significant symptoms that impair their ability to function in a social and occupational sense (including loss of job, housing, and breakdown of relationships) are therefore not necessarily certifiable for involuntary admission under the mental health act in Ontario and the territories. However, the other jurisdictions have a broader definition of harm, without the bodily specifier. Some jurisdictions have "likely to suffer substantial physical or mental deterioration" as an alternative to harm, and while this includes Ontario, there are additional criterion required to detain for mental deterioration, including evidence of previous benefit from treatment, and a finding of incapacity to consent to treatment. The need to be incapable to consent to treatment in order to be involuntarily admitted is not otherwise universal. Additionally, some provinces require there to be a need for psychiatric treatment, which has implications for treatment refusal and the purpose of involuntary admission.

Forced treatment is widely variable across the country. Authorization for treatment is managed by the state in five provinces, ranging from allowing the attending physician to authorize treatment, to the director of the psychiatric unit, to making use of a tribunal or court system. Otherwise, authorization for treatment is handled privately; in which case, the patient's capacity to make treatment decisions is assessed, and, if incapable, a substitute decision maker (SDM) is selected. The criteria that guide substitute decision-making vary, but are typically incorporated considering the best interests of the patient or previously expressed capable wishes [16].

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## 20.8 Education

Psychiatry residency programs in Canada are accredited by the Royal College of Physicians and Surgeons of Canada, an organization that sets national training standards. There is variability in the order and exact length of clinical rotations across the country, but all residents will spend time on general adult inpatient and outpatient, child and geriatric psychiatry, chronic care, consultation liaison (psychosomatic medicine), and addiction units. With respect to emergency psychiatry exposure, a 2013 survey of postgraduate psychiatry training programs in Canada indicated considerable variability in the amount of formal exposure to emergency psychiatry, ranging from 1 to 5 weeks. Most residents train in a designated psychiatric emergency unit located within a general hospital emergency department, with

a multidisciplinary team consisting of psychiatrists, nurses, patient attendants, security professionals, and social workers or other crisis clinicians. In addition to clinical exposure, residents are offered teaching in emergency psychiatry through a variety of formats including didactic lecture, simulated role-plays, online modules, and small group learning [4].

Psychiatry residents in Canada have a dual role as learner and service provider and are routinely responsible for providing on-call coverage throughout their training. While there may be unit and consultation-liaison coverage as part of the on-call experience, the primary responsibility of the resident is usually to support the emergency department, and being on-call provides significant exposure to training in emergency psychiatry. Note that being on-call does not necessarily mean waiting at home by the phone; many programs have in-hospital call, in which residents are expected to remain in the hospital to provide service, and review cases with the supervising staff psychiatrist at home.

In addition to on-call coverage and core clinical rotations, senior residents may choose to pursue additional psychiatry electives in the emergency environment during their elective period. Though emergency psychiatry is not a formal subspecialty recognized by the Royal College, some residents choose to do a clinical fellowship in this area. Although this is not a standardized process, fellows can work with the local psychiatry department to design an educational experience that suits their needs. The Canadian Psychiatric Association, a national, voluntary, professional association, has recently created a Section of Emergency Psychiatry to look more closely at formalization of the discipline and creating a community of practice. It is intended that this section will allow members to exchange information and share experiences regarding best practice, system design, and the effective delivery of emergency psychiatric care, education, and research.

Notably, the Royal College of Physicians and Surgeons is embarking on a multi-year transformational change initiative entitled Competence by Design, which aims to move from a traditional medical educational system to a competency-based medical education (CBME) system [17]. CBME shifts the focus from time on rotation as a marker of competence toward the achievement of specific professional competencies as the basis for resident evaluation and promotion [18]. Medical educators, including those in emergency psychiatry, are now tasked with defining core competencies, determining methods of assessment, and designing curricula that support learners in achieving those competencies. At the University of Toronto, a group has developed milestones and entrustable professional activities (the units of learning in competency-based medical education) for the foundational emergency psychiatry training experience, specific for training in emergency psychiatry [19]. This transition to a new curricular approach provides an opportunity for emergency psychiatrists to critically evaluate the profession and ensure that future psychiatrists meet the needs of the Canadian public.

## 20.9 Quality Initiatives and Quality Assurance

Though emergency psychiatric services have been a part of the Canadian health care system for many years, there is variability between communities and centers as a result of local culture, history, and, most importantly, the availability of resources. Quality improvement initiatives can improve the services provided, and there is a growing interest in using these techniques in mental health services. At this time, there are multiple projects starting up at local levels, including routinely utilizing a dynamic appraisal of situational aggression (DASA) score to prevent violence in the emergency department, ensuring patients receive nicotine replacement at time of triage to reduce agitation, and monitoring time to urgent care referrals to improve access to outpatient services [20]. The development of a community of practice will set the stage for standardization and formalization of emergency psychiatry as a discipline, bring an academic lens to this critical area, and promote excellence in patient care.

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### 20.10 Summary

As a developed, geographically diverse nation, Canada has a publicly funded health system in which physician services and most hospital services are covered by 1 of 13 provincial and territorial health plans. Psychiatric emergency services vary widely in their structure and organization, which is largely a function of location. Although the Canada Health Act entitles all citizens to the same level of services, urban settings will typically have more resources available than their rural counterparts. In rural and remote communities, some patients may need to travel or be transported great distances for a psychiatric assessment. Emergency psychiatric assessment is often completed through a team-based approach, in which an emergency physician and nurse will initially assess a patient and determine whether or not a referral to psychiatry is warranted, either in the hospital or an urgent outpatient basis. Provincial and territorial mental health legislation governs the use of involuntary admission and forced treatment, though these measures are typically only employed in the case of significant imminent risk of harm to self, others, or serious physical impairment. Psychiatric emergency services may be relatively well resourced, with designated short-stay units adjacent to the emergency department, and interprofessional teams providing comprehensive biopsychosocial assessment. Disposition options from the emergency setting also vary depending on local resources, but may include a period of extended observation in a psychiatric short-stay unit, admission to a general or psychiatric hospital, or connection with urgent outpatient psychiatric resources. Patients requiring a higher level of outpatient care may be connected to assertive community treatment teams, which will often liaise with the emergency services to help support patients in crisis.

With the pan-Canadian transition to competency-based medical education, there has been an increased focus on ensuring psychiatry residents acquire the core competencies necessary to practice emergency psychiatry. The Canadian Psychiatric Association has recently created a Section of Emergency Psychiatry in order to promote a community of practice and allow members to share experiences. This is an exciting time for emergency psychiatry in Canada, as there is renewed energy to drive the transition toward best practices, along with new educational initiatives across the country.

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# International Models of Psychiatric Emergency Care: United Kingdom

# 21

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## Abstract

In the United Kingdom, the Crisis Resolution and Home Treatment teams (or their equivalent) provide emergency mental health care in the community, and the Liaison Mental Health services provide emergency mental health care in acute general hospitals. The functions of the teams are distinct from one another and have been developed to carry out highly specialized work in their respective areas. These teams have demonstrated effectiveness in the quality of care and a reduction in the cost of care. While Crisis Resolution and Home Treatment teams continue to adapt to local needs at the community level, there has been a national drive to accelerate the development of Liaison Mental Health services with the ultimate goal that all emergency departments in the country are continuously covered by an onsite Liaison Mental Health team.

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## 21.1 Introduction

The National Health Service (NHS) is the main health care provider in the United Kingdom (UK) [1], serving an estimated population of over 66 million. The majority of the population (over 80%) lives in England, with smaller percentages in Scotland, Northern Ireland, and Wales [2]. The NHS aims to provide free, comprehensive health care to all; the ultimate responsibility for the NHS resides with the government [1].

The NHS is the largest employer in the United Kingdom (UK) and ranks number 5 globally. Of the nearly two million NHS employees across the UK, approximately 60% are employed by the NHS in England [3, 4]. With funding derived from general taxation and national insurance contributions [5], net NHS expenditures in England in 2016–2017 were approximately \$147 billion (£120.512 billion). Of this amount, the investment in mental health was \$11.6 billion, with gradual increases planned in the coming years [6, 7]. The health care provision system is complex and comprises a range of services, including clinical commissioning groups, acute specialist and non-specialist trusts, mental health trusts, primary care services, and independent sector organizations [8].

The basic principles of NHS organization and care provisions across the UK are the same, though there are some differences regarding handling of funding and policy under the devolved governments of Scotland, Wales, and Northern Ireland [9].

In England, ten strategic health authorities, overseen by the Department of Health and the Secretary of State for Health, manage further units that provide services. The Care Quality Commission (CQC) regularly inspects the providers' facilities and carries out the role of quality assurance [9]. The NHS in England, which represents the largest share of the NHS in the United Kingdom and serves the largest population, is the focus of the subsequent sections.

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## 21.2 Emergency Psychiatry Service Structure

The movement of mental health services in the UK toward deinstitutionalization in the later part of the twentieth century led to the development of community-based treatment settings. This reconfiguration process involved the development of acute psychiatric inpatient facilities at district general hospitals and community mental health teams (CMHTs) [10].

Community mental health teams (CMHTs) typically include psychiatrists, psychologists, community psychiatric nurses, social workers, occupational therapists, and other support staff who provide treatment and support to the community; referrals come predominantly from primary care [11]. These CMHTs were the main provider of mental health care in the community until the later part of the twentieth century [12]. However, depending on local resources and demands, further specialized teams developed over time, for example, crisis resolution and home treatment teams, rehabilitation teams, early intervention teams for psychosis, assertive outreach teams, along with improved access to psychological therapy teams [11, 13, 14].



Two distinct teams provide most emergency psychiatric care. Crisis Resolution and Home Treatment teams (CRHTTs) provide emergency services in the community, and Liaison Mental Health services cover the acute general hospitals. However, the level of care provided by these teams, as well as patient satisfaction with them, varies across the country [15].

CRHTTs exist either as specialized teams or as units integrated into the community mental health teams (CMHTs) with dedicated medical and non-medical specialists providing crisis interventions and home treatments. Whether independent or integrated into CMHTs, both types must meet elements of the service delivery objectives of a CRHTT [16]. The key characteristic of these teams is mobility; they must have the capacity to provide care at service users' homes [17]. CRHTTs aim to provide rapid assessment of patients in crisis due to mental health problems and support through intensive home treatment; both serve as alternatives to acute psychiatric admission [18].

The crisis response role was the domain of traditional CMHT until as recently as the 1990s, but such coverage was offered only during office hours. After experimental use during the 1990s, the CRHTT model was adopted nationally in the year 2000 and over 335 teams with 24/7 coverage were developed across England [19]. Investment in the crisis response service has increased steadily over the years. For example, the funding during the 10-year period from 2002 to 2011 increased from just over \$46 million (£38 million) to around \$326 million (£268 million) [20].

CRHTTs, acting as gatekeepers, assess patients in need of admission to an acute psychiatric inpatient facility. CRHTTs also facilitate early and safe discharge from inpatient facilities. However, the adoption of a particular model for these teams is not mandatory and geographical variations are widespread [20].

Introduction of the CRHTT model was met with initial criticism due to limited evidence demonstrating its effectiveness, but a number of studies in the ensuing years have demonstrated it to be cost effective, with decreased admissions to acute inpatient beds and increased service user satisfaction [21, 22].

The improved quality of care provided by CRHTTs include a decrease in the length of inpatient stay, avoidance of admissions to further locales due to lack of available local inpatient beds, access to 24 h emergency support for patients, reduced burdens on the family, and sustained improvements in the patient's mental state demonstrated at 3-month follow-up [18, 23, 24]. A randomized controlled trial with patients in the control group ( $n = 125$ ) receiving care by existing acute services by CMHT, inpatient units and/or crisis houses and patients in the experimental group ( $n = 135$ ) receiving additional interventions by CRHTT showed that, during the 2 months after the crisis, the patients receiving CRHTT interventions were less likely to be admitted to the hospital and the number of treatment visits needed to prevent one admission was 2.65. The CRHTT staff were available around the clock (on call from home overnight) [25].

Another randomized controlled trial carried out in 2009 demonstrated that the average cost for patients receiving inpatient care during an episode of a mental health-related crisis was over \$3000 (£2438) more than those who received solely CRHTT interventions [26]. The results from another study, a cluster randomized

trial published in 2019, showed reduced inpatient admissions but did not show significant patient satisfaction [27].

On the other hand, Liaison Mental Health services in hospitals developed slowly during the last 40 years. The speciality started with a special interest group and has only received widespread acceptance over the last two decades [28]. Liaison Mental Health services are the specialist teams who support the clinicians in general hospital settings, including emergency departments and other wards, by providing emergency and urgent, as well as non-urgent, mental health care [29].

Liaison Mental Health services are accredited by the Psychiatric Liaison Accreditation Network (PLAN), a central project team at the Royal College of Psychiatrists [30]. The accredited teams are explicitly commissioned, planned, and managed against national standards, with appropriate service level agreements and operational policies in place [31, 32].

According to the third annual survey of Liaison Psychiatry, Liaison Mental Health services vary widely across the country and the majority of teams are not currently staffed at the levels recommended to allow them to function as a CORE 24 service (described later in this section) to provide coverage all 24 h. The survey results were based on responses from over 170 (98%) emergency departments out of 177 approached and revealed that, while the majority of the services provided 24/7 care, only 10% had sufficient staffing levels to meet the prescribed standards [33].

As individuals undergoing a mental health crisis are most likely to present to emergency departments after hours, the presence of Liaison Mental Health services at all times is critical [29]. The Care Quality Commission's (CQC) report showed that out-of-hours (after hours) is the peak time for patients undergoing a mental health crisis to be admitted to general hospitals through emergency departments [15].

CRHTTs provide an in-reach service to general hospitals in many areas in England where Liaison Mental Health services are not fully established. However, they are limited in their scope and are not as uniquely integrated with emergency departments and general hospitals as specialist Liaison Mental Health services [29].

Standards require that Liaison Mental Health services attend to a mental health crisis within 1 h, carry out a full assessment to formulate an urgent care plan, make decisions about further referral, and transfer or discharge within 4 h for an emergency assessment. The access to personalized risk assessments and other relevant clinical information required to efficiently meet these response times is not feasible for the CRHTT providing in-reach services to general hospitals. Attempting to meet these response times would compromise the CRHTT's ability to perform its primary function in the community. CRHTTs and Liaison Mental Health teams have distinct specialized functions; hence, a hybrid service cannot meet the service provision needs [29, 34].

Liaison Mental Health services have demonstrable benefits for emergency psychiatric care in the form of swift and compassionate assessments, reduced unnecessary admissions to general hospitals, shorter inpatient stays, improved discharge planning, reduced general hospital readmissions, reduced delays in transfer of care and discharge, and better collaboration between teams providing mental and

physical health care [35, 36]. The cost effectiveness of these teams has been demonstrated by services such as the Birmingham rapid assessment interface and discharge model and the North West London optimal model [37, 38]. The Birmingham rapid assessment interface and discharge model at the City Hospital in Birmingham saved over \$4 million (£3 million) with about 90% of the savings related directly to the services provided to older people. This equals a saving of about \$5 for every \$1.25 (£4 for every £1) invested. Half of these figures resulted from reduced lengths of stay and the remaining from the reduction in readmissions to the general hospital. The introduction of similar models in four hospitals in London resulted in savings of about \$2 million (£1.5 million) [39, 40].

There are three main models for Liaison Mental Health services: CORE 24, Enhanced 24, and Comprehensive, as well as a basic level without continuous coverage, called Core model. All models have a demonstrated impact on cost effectiveness as well as on the quality of care [36, 41].

The Core model is similar to the CORE 24 service but without after hours coverage [29]. The North West London hospitals use the CORE 24 model to provide around-the-clock coverage of the emergency departments. A consultant psychiatrist must be available at all times. Full bio-psychosocial assessments, formulations, and collaborative care plans must be provided within prescribed response times, and the teams have the capacity to provide short-term outpatient follow-ups and brief evidence-based psychological interventions. The teams are expected to collaborate with acute general hospital teams to work toward shortening hospital stays and improving follow-up care [41].

The Birmingham rapid assessment interface and discharge model at City Hospital Birmingham forms the basis of the Enhanced 24 model and has all of the characteristics of the CORE 24 service. Additionally, the teams provide more specialist non-urgent care, extending expertise to addictions and patients with learning disabilities [39]. Comprehensive teams, such as the model used in the Leeds and York Partnership NHS Foundation Trust, have further enhanced non-urgent care expertise in the treatment of complex conditions such as chronic pain and medically unexplained symptoms. The emergency care component of the latter models does not differ [29].

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## 21.3 Emergency Psychiatry Service Systems Flow

A single point of access facility is a standard practice for both CRHTTs and Liaison Mental Health services [20, 31, 32]. CRHTTs are multidisciplinary teams led by consultant psychiatrists and are staffed to ensure 24/7 availability. The team responds to crises due to mental health problems within 1 h of a request for support. Initial support is provided via telephone, followed by assessment and administration of an intensive home treatment plan to prevent hospital admission where possible. An intensive home treatment program is meant to last up to 6 weeks. If a patient is admitted to the hospital, the contact is maintained to facilitate safe and early discharge. CRHTTs work with patients on preventive plans to minimize future crises.

Other community teams, if involved in the patient's care at the time of referral, work in collaboration with the CRHTTs. The consultant psychiatrist's coverage can either be a dedicated role within these teams or may be provided by the clinicians responsible for local CMHTs during office hours and by on-call consultant psychiatrists out-of-hours [20].

If needed, CRHTTs provide short-term respite care and support in crisis houses as well. Crisis houses with non-hospital beds include clinical crisis houses with onsite staff availability, specialist crisis houses aimed at patients with specific needs, crisis team beds fully integrated within CRHTTs, and non-clinical alternatives managed mainly by voluntary sector organizations [16].

The Liaison Mental Health teams are able to provide advice and support to acute general hospital teams to manage the patient while waiting for mental health assessment after referral [29, 30]. The availability of an experienced member of the team at all times allows the ability to discuss potential referrals. Following assessment, a comprehensive assessment and management plan is shared with the acute general hospital team, the patient's general practitioner, and significant others, if patient consent allows [29–32, 42].

The team is able to assess presentations related to dementias and is available to advise colleagues from the acute general hospital concerning the mental capacity of the patients [42, 43]. Links and access to advocacy services for the Mental Capacity Act (MCA) and Mental Health Act (MHA) advocates are well established [29]. The Liaison Mental Health team has the capacity to jointly assess and review patients with other medical teams at the acute general hospitals around the clock [30, 44].

The Liaison Mental Health team sees patients in the emergency department and emergency referrals from other inpatient wards within 1 h of the referral, while urgent referrals from emergency departments as well as from within the hospital wards are seen within 24 h [29, 44]. Emergency and urgent referrals are defined and identified distinctly [30]. Patients referred as an emergency from emergency departments receive full assessment and a copy of their care plan within 4 h of the referral. Patients with alcohol and illicit substance intoxication are jointly managed along with the acute general hospital teams. The Liaison Mental Health team supports these patients and the acute general hospital teams during the process of initial management until the patients' mental health can be assessed reliably once they have reached a sober state [29].

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## 21.4 Patient and Staff Safety Concerns

CRHTTs follow the same safety standards as those of any other community-based mental health service, such as the lone workers policy/standard, to ensure the safety of staff working alone during contact with patients in the community [45, 46]. Staff working in the community prepare for assessments and collaborate with other services in the community (patient's general practitioner, social services, etc.) to share information prior to, during, and after assessments, and to ensure the safety of their team members and the service users [47].

For fully accredited Liaison Mental Health services in acute general hospitals, appropriate facilities in emergency departments are available to conduct high-risk assessments with particular emphasis on the location of the assessment suite, access to and exit from the room, the room layout, an observation panel/window for safety checks, and the presence of a security alarm system. The Psychiatric Liaison Accreditation Network (PLAN) team provides direct support and information to help Liaison Mental Health teams meet these standards and advocates for any required changes to the commissioners and acute general hospital trusts [30].

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## **21.5 Personnel and Staffing: The Psychiatric Emergency Services Team**

CRHTTs are staffed based on local needs and include a team leader, social workers, mental health nurses at various levels of experience, assistant practitioners, clinical support workers, psychiatrists, psychologists, and administrative staff. The team structure and operational policies are developed locally to provide constant availability [11]. The level of experience among staff is described in terms of bands, which refers to the level of seniority based on clinical experience in years as well as qualifications; therefore, staff with increased managerial and leadership roles over the years will have higher bands [48].

For Liaison Mental Health teams, the staffing level and skill mix of the team are reviewed regularly to identify any gaps in the workforce to ensure minimal reliance on temporary staff. The teams are expected to have access to a drug and alcohol worker, a learning disability worker, and a pharmacist. The recruitment process involves the patient and/or his or her significant others; patient representatives contribute to the local service level meetings [31]. Service specification model recommendations for staffing levels are made available for commissioners to follow according to local clinical needs [41, 49, 50].

Liaison Mental Health teams are staffed through a mix of consultant psychiatrists, non-consultant doctors, nurses of different seniority levels, therapists, managerial staff, and administrative staff. Core teams, CORE 24, and Enhanced teams serve acute general hospitals with 500 beds and have an equivalent of 14.4, 25.3, and 23.2 full-time staff respectively. The Comprehensive teams have the equivalent of 69 full-time staff to serve acute general hospitals with 2000 beds [29, 30].

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## **21.6 Considerations of Coordination of Care**

CRHTTs are governed by local protocols that take available resources into consideration and ensure the provision of safe care in a cost-effective manner. Despite some differences in their service structures across the country, the underlying principles of continuity of care are ensured. Each shift is assigned a duty coordinator who is a senior member of the CRHTTs. The duty coordinator leads the comprehensive hand-over meetings at the start of each shift, discusses existing and new

referrals, delegates work regarding assessments and completion of clinical records, and ensures staffing levels for the shift [51].

Similar procedures are followed by the Liaison Mental Health services based at acute general hospital settings. However, they have the additional challenge of coordinating the care among non-connected staff, such as the general hospital teams and community mental health teams. This aspect of the services is audited for successful accreditation [29].

Electronic medical records (EMRs) play a significant role in effective care coordination, especially during urgent and emergency care. EMRs ensure the availability of up-to-date information to help meet the targets for preparation and completion of assessments in a timely manner [52].

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## 21.7 Health Care Funding and Resources

Just over 10% of the UK population accesses health care services via private health insurance policies, mainly through corporate subscriptions [5]. There has been an overall increase in funding to the NHS in recent years, but the funding for mental health services has not increased in parity with the other acute and specialist services. This has had a negative impact on overall patient care due to staff shortages and service gaps secondary to poor or no service infrastructure in places. There are strong recommendations from clinical bodies to increase funding to allow the implementation of relevant guidelines for improvement in service provision [53].

Mental health spending increased by 3.2% in 2017–2018 as compared to the previous year. The *Five Year Forward View* plan published by an independent mental health taskforce in February 2016 sets out recommendations for mental health service development with a particular mention of the development of the emergency psychiatric services and Liaison Mental Health teams. According to the recommendations accepted by NHS England, more than an additional \$1.2 billion (£1 billion) will be invested in the transformation of mental health services by 2020–2021 [54].

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## 21.8 Mental Health Legislation

Legislation relevant to mental health services in England are the Mental Capacity Act (MCA) 2005 and the Mental Health Act (MHA) 1983, amended in 2007.

MCA provides protection, support, and empowerment to individuals aged 16 and over who lack the capacity to consent to care and treatment in emergency as well as non-emergency situations. DoLS teams use Deprivation of Liberty Safeguards (DoLS) to authorize treatment in an emergency. Following this, trained independent DoLS assessors review the situation and determine the actions needed to facilitate continuity of care and treatment [55].

MHA allows for compulsory treatment interventions in patients with mental disorders if the relevant legal criteria are met for detention and admission to the hospital for treatment (or in the community in some non-emergency situations). In public

places, including emergency departments, police can detain an individual using Section 136 of the MHA (valid for 72 h) for an emergency psychiatric assessment. Patients who refuse access to their property can be transported by the police for assessment using a warrant under Section 135. A patient already in a hospital bed (mental health or general hospital) can be held by nurses for up to 6 h to allow a doctor to carry out initial assessments that, in turn, allow holding the patient for up to 72 h. This provides time for further specialist assessment by two senior doctors and an approved mental health practitioner (non-doctor), all of whom are specifically trained and independent of the CRHTTs and Liaison Mental Health teams, if possible. Patients requiring inpatient care against their will may be detained for up to 28 days for further assessment or for up to 6 months for treatment. The admission can be to a general hospital bed with support from a Liaison Mental Health team if the physical health needs outweigh the mental health needs [56].

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## 21.9 Education

The Royal College of Psychiatrists' Centre for Care Quality Improvement (CCQI) has published a Home Treatment Accreditation Scheme with standards relevant to staff skill mix, training, and educational needs. The general principles of periodic supervision and yearly appraisal that apply to all mental health teams are also relevant to CRHTTs. Additional two to three yearly required training updates for CRHTT members include specific topics such as conflict resolution, family and social systems interventions, carer awareness and family inclusive practice, basic counseling, suicide prevention and managing self-harm, solution focused brief therapy, alcohol and substance misuse issues, activity scheduling, diversity awareness, personal safety training, and medication administration competency training [51].

All Liaison Mental Health teams are expected to receive regular updates with respect to the relevant legal framework (MHA and MCA) and have an understanding of general hospital systems, knowledge of care and treatment of older adults, illicit substances and alcohol problems, learning disabilities, and mental health concerns in individuals with physical health problems. All team members require appropriate training in personalized risk assessments and should have knowledge of local services, including social care and voluntary sectors, which allows them to collaborate safely on treatment and risk management plans [29].

Medical members of the team are also expected to have expertise in leadership skills. Nursing members are expected to autonomously complete full biopsychosocial assessments, provide a high degree of clinical leadership, and provide training and supervision for other members of the team. Acute general hospital staff members contribute to the training and education of the liaison mental health teams and vice versa [29].

There is no specific training program for doctors in emergency psychiatry as a specialty/subspecialty. Rotation to training posts in general adult psychiatry, which includes placements within CRHTTs and Liaison Mental Health services at various stages of their training as well as out-of-hours on-call work (an essential part of



training for doctors), provides valuable but variable experience in emergency psychiatry. Training in psychiatry across the UK is overseen by the Royal College of Psychiatrists and has gone through considerable changes over the last decade. The training program is competency based and trainees have to complete workplace-based assessments that demonstrate achievement of curriculum-based competencies for yearly progression to the next level of training. After completing a minimum of 5 years in medical school prior to graduation and 2 years in a foundation internship program with placements in different specialties, doctors can enter core psychiatric training, which comprises a minimum of 3 years. During this time, they rotate in various placements, including general adult psychiatry, old age psychiatry, child and adolescent psychiatry, learning disabilities, forensic psychiatry, liaison psychiatry, and psychotherapy. During the core training, trainees must pass the membership examination (MRCPsych) for the Royal College of Psychiatrists to proceed to higher specialty training/subspecialty training. Doctors choosing to proceed with higher specialty training go through a national recruitment process for approved training posts where they work toward the Certificate of Completion of Training (CCT). The CCT requires a minimum of 3 years of training (longer in some cases, e.g., when working on a dual specialty program) in any of the following six recognized specialties: general psychiatry, old age psychiatry, forensic psychiatry, learning disabilities, child and adolescent psychiatry, or medical psychotherapy. Emergency psychiatry is principally covered by general psychiatry, although old age psychiatry has its own emergency service component in some places [57, 58]. Consultant psychiatrists go through annual appraisals and a revalidation at 5 years based on satisfactory continuous professional development relevant to the scope of their work, including emergency psychiatry experience gained through inclusion in CRHTTs or Liaison Mental Health teams [59].

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## 21.10 Quality Initiatives and Quality Assurance

A national initiative that ensures the quality of medical care across all specialties is accomplished by regular visits of Care Quality Commission (CQC) teams to assess performance of the services against set standards [15]. Additionally, for emergency psychiatry, both CRHTTs and Liaison Mental Health services have central accreditation processes set up by the Royal College of Psychiatrists [30, 51]. Liaison Mental Health teams are accredited by the Psychiatric Liaison Accreditation Network (PLAN), a team at the Royal College of Psychiatrists that collaborates with the Royal College of Emergency Medicine, the Royal College of Nursing, and the Royal College of Physicians and the Mind, which is a mental health charity organization that supports patients and their caregivers [30]. Internal audit processes are also necessary for accreditation and focus on wait times, response times, and other performance indicators that contribute to service management procedures, service developments, and staff supervision [30, 31]. Incident reporting is a quick and effective process that enables teams to learn lessons and respond appropriately through service development [31].



Telepsychiatry is another initiative with the potential to enhance emergency psychiatric care for service users. Telepsychiatry has been experimented with as an innovative way of providing speedy services, especially in the context of minimizing delays due to travel time. The emergency department and psychiatric service in Oxford, England conducted a telepsychiatry trial covering another regional emergency department 27 miles away. The team used it for easy access to senior medical opinion in complex cases, to offer immediate specialist assessments via videoconferencing, and to provide follow-up appointments at convenient times for the service users. A patient expert by experience (peer specialist in the United States) was involved in setting up protocols. The project, which ran for 12 weeks, was well received by up to 90% of patients and saved almost 90 h of clinician travel time and approximately \$1250 (£975.92) in expenses. This study shows the potential for telepsychiatry to provide further cost-effective care while staying within the time constraints for emergency and urgent assessments required by the mental health services [60].

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## 21.11 Summary

Emergency psychiatric services in England are provided around the clock in the community by CRHTTs and at acute general hospitals by Liaison Mental Health teams. Other specialized mental health teams, for example, early intervention for psychosis teams, assertive outreach teams, and perinatal mental health teams, can provide an urgent response to the patients on their workload during normal working hours. CRHTTs have a base but are principally mobile. They function using tailor-made models, according to local needs and resources, to provide home treatment to patients undergoing a mental health crisis. They act as gatekeepers to prevent unnecessary admissions to psychiatric inpatient beds and facilitate early discharge.

Evidence for the effectiveness of CRHTTs has not been overwhelming, but research has demonstrated their relative cost effectiveness compared to inpatient care, and their ability to reduce the number of admissions to psychiatric inpatient beds and the length of inpatient stays. Patient satisfaction has been variable, partly due to a lack of consistent follow-up by the same members of staff. Staff consistency has been difficult to achieve owing to limited resources and shifts in the pattern of staff duties [61].

Liaison Mental Health services, on the other hand, have been well received at acute general hospitals and they have clearly demonstrated cost effectiveness and an improvement in the quality of care. However, Liaison Mental Health services are not fully functional across all emergency departments in the country, with only about 10% of the emergency departments having Liaison Mental Health teams that meet the service standards and achieve accreditation [33]. These teams are currently understaffed and under-resourced at most places, which creates this gap in service. The gap is covered by the CRHTTs providing in-reach services to acute general hospitals. However, this compromises the primary role of the CRHTT, which is to provide emergency service in the community, and the care provided in the acute general hospitals cannot meet the prescribed standards of emergency psychiatric

care. The government of the UK has approved further funding in their *Five Year Forward* plan to provide at least the CORE 24 model of Liaison Mental Health services to all emergency departments across the country. With increased availability of Liaison Mental Health teams in all emergency departments, the burden on the CRHTTs will be reduced, enabling them to redirect their resources back to the community, which could lead to an improved service user experience.

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# International Models of Emergency Psychiatric Care: The Republic of Serbia

# 22

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## Abstract

Emergency psychiatric services in Serbia play a pivotal role in connecting patients who typically receive outpatient care with inpatient treatment options. The Serbian healthcare system provides 24-h emergency care through highly utilized, dedicated psychiatric emergency departments. This chapter presents the current landscape of the emergency mental health system in Serbia and describes the political and strategic undercurrents; this chapter also addresses education and training opportunities in the region for individuals who want to become emergency psychiatrists.

## 22.1 Introduction

The Republic of Serbia is a sovereign state situated in the southern Pannonian Plain of the central Balkans. Serbia borders Hungary to the north, Romania and Bulgaria to the east, Macedonia to the south, and Croatia, Bosnia and Herzegovina, and Montenegro to the west. Serbia also shares a border with Albania through the disputed territory of Kosovo [1].

Of the approximately 7 million people who inhabit Serbia, 1.65 million live in Belgrade, its capital. Novi Sad is the largest city in the Serbian northern province of Vojvodina, with 350,000 residents [1]. Before becoming an independent nation in 2007, Serbia was incorporated into the Socialist Republic of Yugoslavia.

Serbia's healthcare system was very progressive when it was first implemented in the 1970s. At the time, it provided adequate care for Serbian citizens; however, international trade sanctions levied against Yugoslavia between 1990 and 2001 caused major economic distress. The Yugoslavian civil war between 1991 and 1995, followed by North Atlantic Treaty Organization (NATO) bombings in 1999, devastated the land and caused the population to suffer [1, 2]. As a vital part of society, the progressive Serbian health system had to adapt to accommodate the people's needs [1, 2].

Between 1991 and 1995, approximately 350,000 displaced persons (internal refugees), comprised mostly of Serbian nationals from the former Yugoslavian Republic (Croatia and Bosnia), migrated to Serbia. These individuals obtained their health insurance through the international Red Cross or went without any healthcare coverage. This same population was either involved in, or directly impacted by, the Yugoslavian civil war and had a significantly increased need for social and psychiatric services [1, 2]. In 1999, approximately 150,000 refugees from Kosovo made a similar trek to central Serbia where they too obtained health insurance through the Red Cross, or simply went without coverage [1, 2].

Although the civil war and subsequent NATO actions have ended, within the last decade, Serbia has become a "transit country" for between 5000 and 10,000 Middle Eastern refugees (mostly Iraqi, Irani, Syrian, and Afghani) fleeing war and ongoing conflicts in the Middle East. These refugees transit Serbia en route to their final

destinations in Western Europe [1, 2]. Illegal refugees do not have any identification documents or health insurance. Due to rough living conditions, they often are exposed to a higher incidence of violence, injuries, and accidental deaths. They rarely seek any assistance in healthcare institutions due to fear of being reported to the authorities.

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## 22.2 Emergency Psychiatry Service Structure

An economic recession, increased poverty, and social turmoil led to increases in the number of patients needing intensive treatment for health conditions. In turn, the heightened demand for services led to changes in the delivery of care, which then resulted in a dramatic increase in the number of patients seen. In Serbia, some discrepancies exist between the civilian approach to healthcare, and the military approach which is comparable to the Veterans Affairs system found in the United States.

For this analysis, the authors collected information concerning psychiatric emergency care from both the civilian and military branches of the health system in 2017. To ensure a representative illustration, the study examined psychiatric services provided in Belgrade and Novi Sad, as well as emergency psychiatry data provided by the Military Academy in Belgrade. The data presented in this chapter represents emergency psychiatry service utilization for more than two million inhabitants, or more than 28% of the Serbian population [3–5].

Hospital Laza Lazarevic and the Military Medical Academy (VMA) each maintain a registry of emergency psychiatric visits to those hospitals in the Serbian capital city of Belgrade. Because of its prime location in the center of the city, as well as its history (having been established in 1861), Hospital Laza Lazarevic is the dedicated emergency psychiatric facility in the Serbian capital for 6 days out of each week. A rotating schedule between Lazarevic and the VMA designates the VMA as the dedicated emergency psychiatric evaluation site on Wednesdays each week.

If the outpatient clinic provider believes that a patient would benefit from inpatient treatment, the patient will be transferred to a psychiatric emergency department (ED) for evaluation and possible hospital admission. In the Serbian national health system, after evaluation in a dedicated psychiatric emergency department, the patient will be hospitalized, or recommended for outpatient treatment. In the city of Novi Sad, University Psychiatric Clinic is the only provider of emergency psychiatric care. Dedicated emergency psychiatric emergency rooms are fully staffed around the clock.

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## 22.3 Emergency Psychiatry Service Systems Flow

The emergency departments at University Hospitals (Clinical Center Belgrade and Clinical Center Novi Sad) are efficiently organized, and patients meeting inpatient admission criteria are promptly admitted to the appropriate unit. Psychiatric



hospitals are organized into specialized hospital services, a toxicology/addiction unit, a mood disorders unit, and an acute psychiatric care/psychosis unit.

Initially, most patients with psychiatric diagnoses are brought directly to psychiatric emergency rooms. Some patients are brought to the general emergency department, usually following trauma, before providers realize or understand that the condition may primarily be a psychiatric one. After a trauma evaluation and stabilization in the emergency department (as in cases of self-injurious behavior or acute intoxication), patients under the influence of psychoactive substances or alcohol are transferred to the psychiatric emergency department. After evaluating the patient, the emergency psychiatric team will decide whether the primary problem is substance abuse or psychiatric illness. If the primary problem is substance abuse, the emergency psychiatric team decides if an inpatient stay for addiction treatment is necessary. Alternatively, the patient may be sent to a specialized outpatient treatment center following overnight stabilization, or sent home. Likewise if the primary problem is secondary to a psychiatric illness (self-injury, suicide attempt, danger to others, or gravely disabled), the emergency psychiatric team will decide if the patient requires inpatient or outpatient psychiatric care, or discharge home.

“Admit, no bed” is not a common practice in Serbia. If a patient meets hospital criteria for a psychiatric inpatient stay, the patient will not typically remain in the ED for a prolonged period while awaiting hospital placement. Because the government is the insurer and runs the hospital, there are no issues with pre-certifications, insurance approval, preferred placement, or being out-of-network.

Having noted this, there is one exception when “admit, no bed” can happen, which is during a weekend when a psychiatric social worker is not assigned to the night shift. The patient may be transferred to a different hospital if they have a specific diagnosis such as substance use, or if the unit is full. During that night shift, those patients will spend additional time in the ED, but they will be admitted to the acute care unit the next morning, or discharged to go home. In the Serbian system, prolonged stays and extended treatment in the ED are not considered an acceptable level of care.

Patients with addiction or dual diagnoses are admitted directly to special addiction hospitals from psychiatric emergency departments. Similar to the United States, the maximum length of inpatient stay for addiction treatment is 30 days. Those admitted to acute care psychiatric units are also expected to be discharged in less than 30 days. If they require a longer hospital stay, a transfer to long-term units is granted; there are five, state-run facilities that provide long-term hospitalization. Patients are transferred to state hospitals after exceeding the limits of their stay at short-term hospital facilities. Long-term hospitals are also government-run and operated through the national health system.

Serbia has established a specialized chemical dependency treatment network which centers around a special addiction treatment hospital in Belgrade, Teodora Drajzera. This hospital provides both outpatient and inpatient care with specialized outpatient alcohol treatment programs [6]. VMA has its own toxicology inpatient and outpatient services [7]. Finally, the University of Novi Sad Psychiatric Clinic

offers inpatient care while also providing specialized, outpatient alcohol treatment programs [5].

Patients living with addiction account for approximately 40% of all emergency visits. In the University of Novi Sad Psychiatric clinic, 35% of inpatients have a dependency diagnosis. In this clinic, the average inpatient length of stay is 10 days for substance dependence [5].

In Belgrade, the Institute for Behavioral Health, Palmotićeve, also provides in and outpatient services [8], as well as specialized services for adolescents with chemical dependency.

In 2017, Belgrade had 7221 emergency psychiatric patient visits. These evaluations occurred between Hospital Laza Lazarevic (6064 emergency psychiatric visits) [3] and the VMA (1157 emergency psychiatric visits) [4]. Of these evaluations, the Laza Lazarevic Hospital provided treatment for 3635 visits (60% of the total), and 241 patients were admitted (21%). The VMA primarily focuses on military personnel and veterans [4].

Per capita, the rate of urgent psychiatric visits was 434 per 100,000 individuals per year in Belgrade; and the rate of hospitalization for psychiatric symptoms was 193 per 100,000 population [3, 4].

In Novi Sad, there were 4679 emergency psychiatric patient visits in 2017. Following emergency evaluations, 2280 of these patients were admitted to the hospital [5]. The University of Novi Sad Psychiatric Clinic is the psychiatric emergency evaluation site in Novi Sad, Vojvodina's largest city. The hospital provides emergency psychiatric services for close to 600,000 people, though the population of Novi Sad is only 345,000 [5]; the remainder of those treated are from the agricultural Vojvodina region of Serbia. There were 1336 urgent psychiatric visits per 100,000 population in Novi Sad, and 651 per 100,000 were hospitalized following these visits per year [5].

In all, the number of urgent psychiatric care visits in Serbia in 2017 was 595 per 100,000, and the rate of psychiatric hospitalizations following emergency examinations was 307 per 100,000 [3–5].

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## 22.4 Patient and Staff Safety Concerns

Safety incidents occur more frequently in emergency departments than in nonemergency medical settings, and are more common in populations with substance dependence and crime-related trauma [9]. Each emergency department has its own, unarmed, hospital security service. This police force is tasked with patrolling the grounds regularly at university-based hospitals (Clinical Centers in Belgrade and Novi Sad), but they are not specifically assigned to the psychiatric emergency room. Over the past decade, there has been some public discussion about passing a law to protect medical personnel and first responders from attacks from patients or patients' family members; however, at this time, the Serbian parliament has not passed any law to protect first responders.

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## **22.5 Personnel and Staffing: The Psychiatric Emergency Services Team**

A typical psychiatric emergency team is comprised of one or two attending physicians (psychiatrists), one to two psychiatry residents (years 1 and 3), and a social worker. Psychiatric nurses and technicians have working field experience, and are assigned to specific departments, working on a shift schedule. Shift lengths vary for physicians, nurses, and administrative workers.

Record keeping in the psychiatric emergency services department at the clinical centers of Serbia and Novi Sad, like VMA, is electronic.

Upon the patient's arrival at the psychiatric ED, a nurse or technician performs an initial evaluation. Patients are asked to complete an initial patient questionnaire which assesses the referral source (e.g., self, family, friends, police), the patient's chief complaints, and whether or not the police were involved. This initial patient assessment also includes information about the general characteristics of the patient (e.g., agitated, confused, uncooperative, restrained), signs of intoxication, and whether the patient had guns or other weapons. After the initial nursing assessment, a psychiatrist evaluates the patient.

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## **22.6 Considerations of Coordination of Care**

If a patient does not meet the criteria for an inpatient stay in the psychiatric emergency room, the patient will be scheduled for a follow-up visit with outpatient psychiatric services (if warranted). Outpatient services are available as day hospitals for those with chronic mental illness, chemical dependency or addiction, or outpatient clinics for medication management and counseling. Psychiatric patients may also be seen in outpatient multispecialty community clinics, such as Dom Zdravlja. The Republic of Serbia has 152 government-operated multispecialty community clinics, with 19 of those being located in the territory of Belgrade (1 per each county in the city of Belgrade) [10]. Each multispecialty community clinic has established outpatient psychiatric services and provides multispecialty healthcare to their community. This community healthcare system has been in place since 1948 [11]. If a patient does not show progress during a 30-day acute hospital stay, he or she may be transferred to 1 of the 5 long-term psychiatric hospitals.

At present, Serbia does not have any telemedicine services for urgent psychiatric patient evaluation. In general, telemedicine is not an established standard of care for outpatient services in Serbia.

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## **22.7 Healthcare Funding and Resources**

Serbia has instituted a national healthcare system that provides comprehensive and complete mental and physical healthcare coverage. This system is available to all Serbian citizens under the Serbian constitution; therefore, healthcare is considered a constitutional right in Serbia. Under this system, all psychiatric emergency

services and follow-up care are covered [12]. Patients who are citizens of foreign countries that have bilateral agreements with the Serbian government will also be treated without any delay, and at no cost to the patient. Foreign patients who are unable to produce any documents to verify their identity or country of origin will receive initial stabilization for 12 h, again, at no cost to the patient.

Additionally, under the Serbian healthcare system, no patient evaluated in a psychiatric emergency room will be billed a co-pay or forced to obtain co-insurance. The national healthcare plan fully covers urgent psychiatric visits. There is a nominal cost to the patient of 50 cents per day for either an acute psychiatric hospital or psychiatric day hospital stay [12]. It should be noted that all hospitals charge this same fee for a hospital stay, and the prices are prominently displayed on government websites and near admission desks when patients are checked into the hospital [13].

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## 22.8 Mental Health Legislation

Serbia has mental health legislation that is very specific with respect to voluntary treatment, and clearly defines procedures for involuntary commitment. Serbian mental health laws are in place to prevent abuse and discrimination, outline conditions for emergency guardianship, protect patient privacy and dignity, dictate advanced medical directives, and describe the roles of mental health providers and patients. Patients who present for a mental health evaluation will be examined by a psychiatrist in the psychiatric emergency room. If a patient meets the criteria for an involuntary hospital stay, he or she will be admitted to the appropriate inpatient unit under a “petition pending” status. A psychiatric treatment team, or “consilium,” that consists of at least two psychiatrists and one other healthcare worker, provides a second opinion in less than 24 h. This team’s opinion regarding the petition for involuntary commitment will be sent to a court of law. When such a petition is received, the court will initiate urgent legal proceedings, and is required to hand down their decision on the petition for involuntary hospitalization no more than 72 h after the initial submission of the psychiatric evaluation. The current law was implemented in 2013 [13].

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## 22.9 Education

Serbia has five state-sponsored medical schools. Graduation from medical school is followed by a 4-year residency in psychiatry. Residency programs have very specific rotations similar to those encountered in the United States. Each resident will spend a predetermined amount of time on the consult and liaison service, inpatient units, outpatient units, day hospitals, addiction services, and child and adolescent psychiatry; emergency psychiatry and the consult rotation provide a total of 6 months of experience during the residency. To successfully complete a residency program and earn the ability to practice medicine as a psychiatrist, the resident must pass a psychiatry board certification exam.

Additionally, the Serbian Military Academy has its own medical school and residency programs in psychiatry. Like the civilian universities, military residency in psychiatry is 4 years long and requires a passing score on the psychiatry board certification exam to be able to practice upon graduation.

For psychiatrists in training, there is no fellowship or subspecialty available specifically for emergency psychiatry.

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## 22.10 Quality Initiatives and Quality Assurance

Every board-certified psychiatrist is required to complete at least 20 h of Continuing Medical Education (CME) per year, with a total of 140 h of CME in a given 7-year period. The Serbian Medical Chamber (board) renews physicians' licenses every 7 years, assuming that all required training has been met [14]. Physicians who have not completed the CME requirement will not be able to practice medicine until they have satisfied these duties, and a remediation mechanism that includes 1 month of nonclinical duties is imposed until the CME requirement is met. The Serbian Medical Chamber posts the names of physicians who have valid licenses, as well as announcements about suspended physicians and disciplinary actions on its publicly available website [15].

The Serbian government has also made recommendations for improving service utilization, such as providing procedures for transferring patients from acute units to longer stay treatment units when it is deemed medically necessary. Examples of necessary transfers include situations in which the patient does not respond well to therapeutic interventions, or is noncompliant with treatment. After 30 days in an acute inpatient unit, patients with persistent mental illness are transferred to longer-term hospitals. Standards of care provided by the mental health law [13] are in place to ensure proper patient treatment in an appropriate inpatient unit. Length of stay in the hospital is determined by the principal treatment team responsible for the patient's well-being.

Patient rights are clearly defined by mental health law [13] and patients have the right to file written complaints (*knjiga zalbi*) if they are unsatisfied with the way they were treated, as well as the right to file any other complaint they wish. All complaints are subject to official review by the Patient Advocacy Office (*Zastitnik prava pacijanata*) [16]. A patient advocate is a member of the Patient Protection Division of the Serbian Health Department. In every hospital, each department has its own complaint collection box or book which provide patients with the opportunity to submit their complaints or observations to the patient advocates.

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## 22.11 Summary

Psychiatric emergency services in Serbia include 24-h access in either civilian or military medical centers. Follow-up after an emergency evaluation includes inpatient care, outpatient care, community mental care, specialized addiction treatments,

and long-term psychiatric hospitalization. National health insurance provides coverage for citizens of Serbia in these facilities with a nominal copay for service. Private outpatient care is also an available option. Mobile crisis teams are not currently available. Mental Health Law (2013) regulates patient rights and delivery of appropriate psychiatric care [13].

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# International Models of Psychiatric Emergency Care: The State of Qatar

# 23

Adel S. Zaraa

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## Abstract

A variety of cultural, legal, and ethnic influences have led to an increase in mental health-related emergency department (ED) visits in Qatar. Patients who experience psychiatric emergencies often require resources not available at the general hospital, and require transfer to an appropriate psychiatric facility such as the emergency department of Hamad General Hospital (HGH), the only hospital that provides psychiatric services in the country. In May of 2014, Hamad General Hospital established the psychiatric emergency service (PES) as an innovative and pioneering psychiatric liaison service based in the ED of

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HGH. This chapter describes this model of psychiatric emergency services that successfully reduced response time, boarding time, and disposition when compared to previous years.

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## 23.1 Introduction

Qatar is a Middle Eastern country with significant oil and natural gas reserves, located on a peninsula bordering the Persian Gulf and Saudi Arabia. Since 1995, there have been sweeping political reforms and unprecedented economic investment. A peaceful change of power in 2013 established a government that placed priority on improving the domestic welfare of Qataris. Changes included the establishment of advanced healthcare and education systems, and the expansion of the country's infrastructure. The majority of the 2.3 million inhabitants are clustered in and around the capital of Doha; however, only 10–12% of the inhabitants are Qatari nationals [1]. The remaining populace is comprised of members from at least 52 different ethnic backgrounds, and are known within Qatar as expats. The majority of the overall population are males between 18 and 45 years of age [1]. Approximately 68% of the populace practices Islam, while 14% are Christian and 14% are Buddhists. The primary languages are Arabic (official) and English [1]. The government is an absolute monarchy, with a mixed legal system of civil and Islamic law. Healthcare planning, infrastructure, and oversight in Qatar are under government control. The national health insurance, also under government control, provides free basic emergency and primary care coverage.

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## 23.2 Emergency Psychiatry Service Structure

Hamad General Hospital's (HGH) emergency system is one of the busiest emergency services in the country. HGH logs around 1500 emergency department (ED) visits a day, or approximately, half a million visits per year. The annual number of visits to all emergency departments of Hamad Medical Corporation was 1.2 million in 2018 [2]. HGH has the only ED in the country that accepts psychiatric patients. Although psychiatric visits do not exceed 2–3% of all ED visits, an average of 20–30 psychiatric patients are seen approximately every 24 h [3].

Non-Qatari, or expat patients, generally come from low socioeconomic backgrounds and have little to no education; hail from a variety of different systems of beliefs, language, and customs; and hold differing beliefs and views of mental illness. Many suffer from the stressors of hard labor and crowded camps, which means that this population meets many of the risk factors that predispose individuals to the onset or exacerbation of new or pre-existing mental illness. Although Qatari nationals only constituted 10–12% of the population, they represented 42% of the patients



presenting to the emergency department (ED) [1]. This was due, at least in part, to increased mental illness secondary to genetic pool concentration; it is estimated that the marriage rate between first cousins (consanguinity) constitutes almost 54% of all marriages [4–6].

Because of the absence of community-based support institutions, including peer support groups and outreach programs in Qatar, and because the number of inpatient beds stayed the same for almost 35 years, it became clear that the healthcare system was facing a bottleneck problem when it came to admissions or outpatient referral for mental health issues. This reality dictated the need for a fast and intensive intervention, thus creating a “de facto” psychiatric intensive care unit (PICU) in the emergency room.

Initially, on the morning shift, the psychiatrist was part of the psychiatry department hosted by the ED, and on-call psychiatry residents covered the afternoon and night shifts, with telephone support from a psychiatrist or psychiatric consultant. A senior consultant psychiatrist, a staff psychiatrist, and a senior resident in psychiatry constituted the nucleus of the Emergency Psychiatric Service (EPS) team.

In 2014, a comprehensive psychiatric emergency service (PES) was established and became a core service of the ED similar to trauma, cardiology, toxicology, and surgery. The head of the PES was hired and employed by the ED as part of the ED faculty, was responsible for clinical work, and assisted in the development of clinical pathways, treatment protocols, and policies. In response to the Qatar National Mental Health Strategy 2013–2018 [7], a psychiatric emergency fellowship training program was created with three fellows accepted every year; the team also included two full-time psychiatric nurses and access to social services.

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### 23.3 Emergency Psychiatry Service Systems Flow

Patients arrive at the ED from various sources as depicted in Table 23.1. As the result of a scarcity of psychiatric beds and obstacles to discharging patients, patients who need admission to the 67-bed psychiatric unit are initially kept in the ten-bed ED unit for psychiatric care, and are treated as if they are in an acute psychiatric care unit. There are also non-clinical factors that contribute to prolonged stays in the ED as described in Table 23.2.

On the patient’s arrival, the ED psychiatrist serves as the attending of record, orders all necessary tests, consults with other disciplines as appropriate, and initiates treatment. The psychiatrist has scheduled rounds twice a day, titrates medications, and orders a sitter as needed; in short, they do everything that would be done on an inpatient unit. On numerous occasions, severely mentally ill patients are admitted to the inpatient psychiatric unit, but remain, and are treated for many days in the ED (“boarded”). Once stabilized, the patients are discharged and followed up with in the outpatient clinic within two working days of discharge.

**Table 23.1** Referral sources for psychiatric evaluation in the emergency department

Source	Reason for referral	Comment
Field	Any culturally unacceptable behavior.	Most referrals display symptoms of heat exhaustion with confusion and disorientation.
Family	Threatening behavior toward family member(s).	Culture and traditional family structure has a high tolerance for a family member who suffers from mental illness.
Police	Homelessness, loitering, physical altercations, or threats	These behaviors are prohibited in Qatar, and police bring patients to the ED after being called by neighbors or family members.
Prosecutor	Personal claim or demonstrated evidence of mental illness for pretrial evaluation.	The forensic psychiatry service does not cooperate with the court system. Usually a court order mandates a 15-day hospitalization for observation and evaluation.
Correctional and Deportation Officials	Substance abuse, malingering, fights, suicidal gestures or attempts in the prison system or the deportation camps.	These are direct causes for bringing the involved individuals to the ED for psychiatric evaluation.
Airport	Any suspicious behavior, loudness, confusion, or disorientation.	These behaviors trigger the authorities to send the person to the ED for psychiatric evaluation.
Public and Private Hospitals	All suspected psychiatric patients are transferred to HGH for evaluation and management.	None of the eight general hospitals or numerous smaller private hospitals has a psychiatrist available in their ED.
Psychiatric Hospital Outpatient Clinic	The scarcity of psychiatric beds results in the outpatient clinic admitting to psychiatry through the ED.	The EPS provides intensive psychiatric treatment and management, often housing the patient in the ED until the patient improves and is discharged from the ED to follow-up with the outpatient clinic.

## 23.4 Patient and Staff Safety Concerns

In spite of improvements in care, the reality of utilizing the ED for inpatient style psychiatric treatment is not without unnecessary and increased risks for the psychiatric patients, other patients in the general population, and the ED staff [8, 9]. Psychiatric patients are seen in beds scattered across the entire emergency department, only separated based on gender and whether or not the patient is a Qatari national or foreigner. In addition, since all patients remain in street clothes, ED staff has difficulty locating them if they stray from their assigned bed. When boarded with the general ED patient population, several factors contribute to the substantial risk these patients present to themselves and others (see Table 23.3). Complications arise as staff may not receive training for interventions in cases of violent outbursts. As a result, there are numerous physical attacks on staff. Another consequence is that the mentally ill patient might abscond and pose a danger to themselves or others in the community.

**Table 23.2** Non-clinical factors contributing to prolonged stays in the emergency department

Contributing factor	Comment
“Deliver and leave”	Some families bring the patient to the ED, then refuse to take him/her home and insist on a prolonged psychiatric admission regardless of the lack of clinical indication. The absence of social services and community safe housing renders it impossible to discharge such a patient.
“Sponsor” refused responsibility	Every non-Qatari national (expat) must have a local national who serves as a legal sponsor. Many times the sponsor refuses to assume the responsibility to accept a “mentally ill” employee back into his/her workforce. The only recourse is to refer the patient to the deportation authority, because without a sponsor, an expat becomes illegal in the country. That process may take many days while the patient is lingering on a cot in the ED.
Police too “busy”	Patients brought in by the police for a myriad of reasons have to remain in the ED until the police representative can pick up the patient, in most cases simply to release him/her on their own reconnaissance.
Wait for Embassy translator	Some patients are from an ethnicity that speak a rare language or dialect. Care is delayed until the appropriate embassy can send a translator.
Airline representative unavailable	Transit patients from the airport who are brought in for a mental status examination or psychiatric evaluation as a clearance for further travel are required to remain in the ED until an appropriate flight is scheduled or the representative has time to provide transportation back to the airport.

**Table 23.3** Factors contributing to aggression in the emergency department

Factor	Comment
Lack of environmental control	The ED is divided into two general areas: The Qatari and the Non-Qatari areas; furthermore, each area is divided into female and male areas, with separate access doors, ambulance driveways, and waiting rooms.
Lack of differential clothing	Only unconscious or intubated patients are dressed in hospital gowns; the rest are in their street clothing, contributing to difficulties distinguishing patients from visitors or from some staff.
Unlimited visitation	No limit on the number of visitors or time of visit.
Lack of staff ability and/or willingness to restrain patients	Staff refuse to be trained in restraining, subduing, or stopping patients from leaving because the hospital refuses to provide legal immunity or insurance for any consequence.
Lack of authority of security personnel	Hospital security is present but has no authority to touch, restrain, or stop a patient from leaving.
1500 patient visits per day	Chaos and long waits are inevitable; combined with poor logistics and multiple linguistic barriers, the temper volatility is inevitable.

## 23.5 Personnel and Staffing: The Psychiatric Emergency Services Team

The Qatar National Mental Health Strategy 2013–2018 [7] provided funding for additional psychiatric training to meet the needs of the population. A psychiatric consultation liaison/emergency (CL & ED) fellowship training program began in September of 2014 with three fellows every year. Funding for this program covers

three fellows and invited faculty annually. The team also includes two full-time psychiatric nurses who are responsible to conduct triage, obtain patient history, and gather any pertinent collateral information. As a result of this program, by the end of 2015 the PES team grew to include two more psychiatric consultants, two psychiatric specialists, and two to four residents at all times.

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### **23.6 Considerations of Coordination of Care**

The team approach to patient management proved to be the most beneficial in improving outcome, decreasing the length of stay, and minimizing adverse reactions and medical mistakes. Every patient receives a complete history and physical upon registration, regardless of the primary complaint that brought them to the ED. Further medical investigation and consultation are dictated by the initial findings, age, medical history, and presenting complaints. Patients needing admission to an acute psychiatric bed, or an early outpatient appointment, are handled by the nursing staff who contacts the bed manager and/or the outpatient scheduler. Social services are helpful in establishing relationships with the authorities. Any contacts with the police, the court system, and the patient's legal guardians have to go through social services first. Doctors, nurses, and other staff members are not allowed to contact those entities independently. Since the psychiatric hospital is not part of the main campus of Hamad Medical City, patient transport is strictly done by ambulances that are well equipped [10], and their cooperation is swift and professional.

Under certain circumstances, care also needs to be coordinated with the hospital administration. For example, if a "VIP" (very important person) arrives to the ED for any reason, the staff is required to contact administration, who take over the room assignment, the food services, and name the doctor and staff members who will have contact with that VIP. Administration also decides when that person will be discharged from the ED and where they will go afterwards. Additionally, administration has to be involved whenever there is a potential conflict with a Qatari national in the ED.

Last but not least, care has to be coordinated with religious or traditional healers. Qatar is an Islamic State that follows a strict school of Islam. The belief that any mental illness is the Wrath of Allah, or a sign that the afflicted person is under an evil spell or possessed by Jinn, is well rooted in the population [11, 12]. Possession states can only be understood through a combination of biological, anthropological, sociological, psychopathological, and experimental perspectives. The patient's own interpretation of what is happening to them also has to be taken into consideration. Coordinating with religious or traditional healers promotes collaboration, even if it has little bearing on the treatment given.

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### **23.7 Healthcare Funding and Resources**

Qatar is a wealthy country that boasts the highest average individual income in the world at US\$123,000 per year [13]. Healthcare expenditures represented 2.2% of the annual national budget in 2014 and did not change in the subsequent years; nor did the

share of the health budget designated for mental healthcare, which remained steady at 2%. The per capita general health expenditure stood at US\$3071 per year, per person in 2014 as compared to US\$9036 per capita for the same year in the USA [14].

The State of Qatar provides universal health insurance and access to more than 2.3 million residents, tourists, and transit passengers, regardless of their pathology, ability to pay, country of origin, mode of arrival, or legal status. This policy allows healthcare personnel and patients to take whatever medical measures are needed to best serve the patient without worrying about pre-authorizations, denials, or repercussions.

There is limited funding and resources for children with mental disabilities, cerebral palsy, and rare conditions; and for children diagnosed with autism and Down syndrome. Qatar has one central, special institute that provides limited outpatient services to a limited number of clients below the age of 18 [15]. Once these individuals reach the age of 18, they are not offered any services or support from the community or specialized centers such as daycare, rehabilitation centers, or vocational training. The ED is the only place to turn when an individual from this population becomes agitated, violent, or acts out. In the absence of community-based resources, the emergency room and the families of this population have a difficult time dealing with these patients.

Red tape and rigidity stand in the way of developing the mental health system at a faster pace despite the available funds and resources. For example, although there is a clear need for expansion and increased access to beds in psychiatric hospitals, any attempt to accelerate the process is met with resistance. The government's standard response is that it is part of the long-term strategy and cannot be changed before it's time.

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## 23.8 Mental Health Legislation

Up until 2013 when Qatar's National Mental Health Strategy (NMHS) was introduced, Qatar operated without any mental health act; however, the government did recognize that the mental health needs of its population were inadequately addressed [7, 16, 17]. It was very difficult to hold or commit anyone, regardless of the risk they presented to themselves or others, or the severity of their mental illness, unless a police or prosecutor order was obtained to do so. The NMHS Act of 2013 was mostly a combination of the British Mental Health Act, with additions that conformed to, and incorporated, traditional and cultural aspects of the Qatari society.

Although the mental health act was updated, the penal code continues to reflect the criminalization of certain aspects of mental illness, including attempted suicide. That limitation makes it almost impossible for a patient who attempts suicide, or commits an intentional act of self-harm, to come forward and seek help for the injury itself, or for the underlying psychiatric disorder [18, 19]. Additionally, adultery, sexual assault, domestic violence, illegitimate pregnancy, and abortion are considered mandatory reportable felonies, and carry penalties of imprisonment and/or fines, with stiffer punishments levied on the treating physician if they fail to inform the relevant authorities [20–23]. Since every female of child bearing age who comes

to the ED is tested for pregnancy whether she agrees to the test or not, many patients refrain from seeking help for any reason, not only for psychiatric problems [24]. It is difficult to estimate the psychological harm that is imposed by this significant barrier to accessing care.

In a very religious, Muslim country like Qatar, alcohol is prohibited, and only certain foreigners may buy it from a government-run dispensary; and only after undergoing a strict vetting process for religious affiliation and income level. The individual also needs a license to buy alcohol, which is a government issued special ID card. The amount of alcohol that such a license-holder is allowed to buy cannot exceed a certain percentage of their monthly income [25, 26]. As a result, most alcohol abusers are closet drinkers and rarely come forward to seek treatment; therefore, most of the cases that present to the ED are patients who are severely intoxicated, in a state of severe withdrawal, or display signs of Wernicke's. The same is true of hardcore opiate and other drug abusers. Treatment is offered for withdrawal, but there is no long-term treatment option, or appropriate and adequate follow-up, leading to a revolving door in the ED.

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## 23.9 Education

Medical schools in the majority of the Middle Eastern countries involve a 6-year program immediately after high school, and psychiatry is not part of a student clerkship. The psychiatry residency in Qatar is a separate, 4-year ACGME-I accredited program, and is affiliated with Weill-Cornell Medical College-Qatar. The newly established psychiatric emergency services have opened multiple venues to educate, treat patients, and perform research.

The Fellowship in Emergency Psychiatry training program attracts many senior residents from the local residency program, as well as from other countries, including Saudi Arabia and Spain. The fellowship lasts for 3 years, and combines education, research, and service with an end-goal of independent practice as a consultant in Consult Liaison and Emergency Psychiatry. In addition, emergency room physicians must attend three psychiatric continuing medical education (CME) modules on suicide screening, delirium screening, and the BETA project (Best Practices in Evaluation and Treatment of Agitation) [27]. The senior consultant psychiatrist is responsible for developing the curriculum for the ED residents' psychiatry rotation, and participates in at least three educational modules per year for the ED attending physicians. Daily CL & ED didactic and case presentations are open to all practitioners.

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## 23.10 Quality Initiatives and Quality Assurance

All residents, fellows, and attending physicians must complete research training (Collaborative Institutional Training Initiative). Research and clinical improvement projects have streamlined therapeutic approaches that include treatment algorithms and operational policies. The hospital collects detailed information from each

patient that includes the time of patient arrival and discharge, demographics, length of treatment, mode of arrival, use of physical restraints, rates of absconding, and falls. For patients who regularly utilize emergency treatment, the frequency of their ED visits and drug-seeking behaviors lead to specific treatment plans.

The newly-developed PES service in a Qatar's major general hospital achieved rapid improvements in care. In less than 2 years after publication, the Best Evidence Based Treatment of Agitation (BETA) became a national clinical policy to manage agitation in the State of Qatar [27, 28]. Alcohol withdrawal was standardized with two pathways: The CIWA pathway and the Lorazepam fixed dose pathway [29, 30]. Screening for delirium using the Stanford Proxy Test for Delirium (SPTD) [31] increased the clinical diagnosis of delirium from 5.3% to 19.55% of all admissions, which resulted in improvements in care [32].

After the PES became fully functional, disposition, defined as the time from registration to the time of the clinical decision regarding the post-ED care, was the single most improved domain in patient care. The wait time to be seen, evaluated, diagnosed, and disposition made, improved 37-fold [33]. A thorough evaluation, combined with a bedside psychotherapeutic intervention, suitable psychopharmacology, and the provision of a follow-up appointment, decreased the total number of psychiatric admissions by 18% [33].

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## 23.11 Summary

The introduction of the psychiatric emergency services program in the nation-state of Qatar, coupled with the continual improvement process in refining this program, has resulted in a safer and more effective treatment model for the mentally ill within its borders. Although the program is still relatively new, this is a promising indication that the PES, as part of the global healthcare improvement and expansion of logistics in the State of Qatar, is poised to continue to provide better, more efficient, and safer treatments for the mentally ill in the ED of the hospitals in Qatar.

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# International Models of Emergency Psychiatric Care: Pakistan

# 24

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## Abstract

Pakistan is the sixth most populous country in the world. Rapid population growth, limited resources, and political and social instability have created a tremendous need for mental health services, including emergency psychiatric care. Currently, there are almost no emergency psychiatric services in Pakistan due to a limited mental health budget, a limited number of qualified mental health

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professionals for such a large population, and no specialized emergency psychiatric care providers. In response to this need, the World Health Organization (WHO) has recently started a pilot program called the Mental Health Gap Action Program (MHGAP) to improve services for mental, neurological, and substance use disorders in Pakistan.

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## 24.1 Country Demographics and Information

As the world's sixth most populous nation, the estimated population of Pakistan is over 200 million [1]. Almost one-third of the population lives below the poverty line [2]. The main languages spoken in Pakistan are Urdu, English, Punjabi, Sindhi, Saraiki, Pashto, and Balochi. There are numerous regional languages and dialects [3]. Punjabis are the largest ethnic group, followed by Pashtuns, Sindhis, Saraikis, and other minority groups [4]. The country is overwhelmingly Muslim (96%), with Christians, Hindus, and other religions comprising the remaining 4% [5]. The World Bank has categorized Pakistan as a "Low- and Middle-Income (LMIC)" country [6]. Thirty-four percent (34%) of the population is under the age of 15, and 7% is above the age of 60. Sixty-eight percent (68%) of the population lives in rural communities. The life expectancy at birth for both males and females is approximately 65 years. Literacy estimates note that 62% of men and 37% of women are literate. Medically speaking, it is estimated that there are only 85 general practitioners and one hospital bed per 100,000 people [7].

Experts calculate the number of outpatient mental health facilities to be just over 3700, with only 1% of these facilities providing services for children and adolescents. While 46% of outpatient facilities provide follow-up in the community, only 1% have mobile mental health teams. There are five mental health hospitals integrated with these outpatient facilities, and just over 1600 beds in other facilities, such as homes for individuals with intellectual deficiencies and inpatient detoxification facilities [8].

It is further estimated that there are between 600 and 4000 psychiatric inpatient unit beds, mostly community based, with approximately 1% of that number reserved for adolescents and children [8, 9].

In Pakistan, like other low- and middle-income countries (LMIC), mental health ranks very low in national health care priorities and its impact on overall health and the economy is rarely analyzed [10]; however, infectious diseases, children, and maternal health care are extensively studied. Nonetheless, in the last decade, non-communicable diseases (NCDs), including mental health disorders, have gradually assumed increasing importance in the health care landscape [11]. Rapid urbanization, decades of economic and political instability, terrorism, and geopolitical tensions have all potentially contributed to the increased prevalence, disability, and deaths caused by mental health disorders. Nevertheless, mental health has been low on the priority list of successive governments. Public health spending is less than

1% of gross domestic product (GDP), and mental health does not have a separate budget [12]. Available health services, such as they are, exist mainly in urban areas. Because of this, the distance to travel for basic health services is a major deterrent for most patients.

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## 24.2 Emergency Psychiatry Service Structure

Pakistan inherited three large “insane asylums” in the cities of Hyderabad, Peshawar, and Lahore from British India in 1947 at the time of independence [13]. These facilities were little more than “holding centers,” more akin to prisons than hospitals. They were run according to the Lunacy Act of 1912 and were staffed by general duty medical officers and nurses, not psychiatrists. With the manifold logistical problems facing the new nation-state, psychiatry was not even mentioned in the first five or six Five-Year Plans. The first psychiatric treatment and training centers were not established until 1965, in the cities of Karachi and Lahore [14]. In the years to follow, psychiatric teaching units opened in most teaching hospitals attached to medical colleges. At the same time, private mental health and substance abuse treatment facilities also began to appear in most major cities, but rural and semi-urban areas remain devoid of any mental health services or facilities. Currently, there are several dozen psychiatric teaching units attached to public and private medical colleges; however, the total number of qualified psychiatrists practicing in the country is only around 400, leading to an alarming ratio of one psychiatrist for approximately every 500,000 people [8].

Unlike most Western nations, all aspects of mental health services are dependent on several factors including national, provincial, and local governments; donor organizations; tribal and religious elders; families; non-government organizations; philanthropists; and others. Additionally, other factors, such as gender, religion, culture, and socioeconomic status, influence mental health services [15]. Large public hospitals are generally overcrowded, with little time or resources to devote to comprehensive patient care, yet these hospitals provide services at minimal cost for the vast majority of the population. Pakistan has no public or private health insurance as it's known in most Western countries, but those who can afford the out-of-pocket fees charged by private community clinics or hospitals may use them. Specialized psychiatric services such as geriatric, forensic, child and adolescent, substance abuse, or psychotherapy services either do not exist or are available in only the most rudimentary forms [16, 17].

Patients and their families who experience mental illness generally do not seek out mental health professionals as a first option. Rather, they first seek out traditional or religious healers, especially in rural areas. Only when these measures fail will patients and families seek help from the mainstream health system [15]. When patients in rural areas do seek mainstream health care services, they typically first go to the Basic Health Units or Rural Health Centers in villages, but these units and centers are generally significantly understaffed and ill-equipped to deal with their issues. As a result, these facilities tend to send patients to the secondary-level

district hospital in quick order, from which point they may be sent on to tertiary-care psychiatric teaching centers (located in large public hospitals). In many cases, individuals may elect to bypass the rural health care system and self-refer directly to a tertiary-care hospital, or if they can afford it, to private psychiatric clinics or hospitals.

The accident and emergency departments (EDs) of public hospitals handle most acute psychiatric emergencies such as suicide attempts, agitated or violent behavior, substance intoxication or withdrawal, or delirium [18], but in general, EDs in the majority of public hospitals lack the staff and training to handle psychiatric emergencies. They have no dedicated psychiatric beds, no 24-h psychiatric coverage by trainees or faculty, and no provision to assess or admit psychiatric patients after-hours. A handful of hospitals, including the Aga Khan University Hospital in Karachi, provide 24-h psychiatric coverage in the ED, but these are rare exceptions [19]. Psychiatric patients referred to a public hospital are assessed in the outpatient clinic during regular working hours (8:00 am to 2:30 pm). Treatment, including the decision to admit for inpatient treatment, is provided on-site, although acutely agitated, manic, or psychotic patients are generally promptly admitted for inpatient treatment. Because all treatment is provided on a walk-in basis, clinics are frequently inundated by a huge number of patients, which often leads to rushed visits and increases the chances of misdiagnosis and poor treatment outcomes. Patients who need services after-hours are either directed to the ED, where they are usually met by non-psychiatric physician trainees who are poorly equipped and trained to handle psychiatric illness, or they may access the myriad private clinics or hospitals scattered over the large and mid-sized cities, if they can afford it.

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### 24.3 Emergency Psychiatry Service Systems Flow

The quality of care at private psychiatric clinics varies from adequate to abysmal. Some are operated under the supervision of psychiatrists, some by general practitioners with minimal psychiatric training, and many by untrained workers with no formal education or training in mental health. The media regularly reports horror stories about the inadequate and at times dangerous “treatment” provided at these centers. Public hospitals, all of which are attached to medical colleges and universities, provide a somewhat better quality of care since all have affiliated departments of psychiatry with trainees and faculty on-site. Even though psychiatric trainees and faculty do not rotate through the ED during normal working hours (8 am to 2:30 pm), psychiatric consultation is available for patients presenting to the ED via the psychiatric outpatient clinic, or the psychiatry department consult team. There is a significant gap in coverage after hours (including holidays and weekends) when psychiatric consultation is not available for patients coming to the ED.

While emergency psychiatric care, however inadequate, is available to the urban population, patients in rural areas face much greater challenges in accessing even the most basic mental health services and psychiatric emergency care, although this

situation is not unique to Pakistan. Multiple studies have shown that most medical resources in LMICs, including psychiatric care, are heavily concentrated in urban areas. One study from India showed that the main reason for lack of compliance with antipsychotic medication was the need for patients and their families to travel long distances to reach their closest mental health outreach clinic [20]. In actual practice, there is no psychiatric care, emergency or otherwise, available in most rural and peri-urban areas. Patients, accompanied by their families, travel on their own to the nearest city and access the available public or private resources there. This frequently results in long delays in treatment, misdiagnosis, and poor short- and long-term outcomes [21].

Because of the overall scarcity of psychiatric services, access to services is also restricted due to the enormous number of patients seeking services in both public and private settings. The average outpatient psychiatric clinic in a public hospital will typically serve between 150 and 200 patients every day, six days a week. A psychiatry department head at a large public hospital in Karachi, Pakistan's largest city, informed one of the authors that his department regularly evaluates and treats around 600 patients each day [22]. The situation is not much better in the private sector. Busy psychiatrists conducting evening clinics in cities can see anywhere from 30 to 100 patients each day. One senior psychiatrist in Pakistan's largest province, Balochistan, which has an acute shortage of mental health services, told one of the authors that he has seen around 300 patients in one day at his private clinic [23]. Patient volumes of this magnitude lend themselves easily to misdiagnosis and mismanagement of both routine cases and psychiatric emergencies.

Clinic or hospital staff evaluate the patient and decide if inpatient admission is necessary. Admission requires consent from either the patient or their family since involuntary, court-ordered commitment for treatment is still not practiced in Pakistan, despite being part of the Mental Health Ordinance [8]. If the patient and the family agree to inpatient treatment, an inpatient bed can usually be found quickly. Pakistan's oldest hospital, Mayo Hospital, located in the northeastern city of Lahore (Pakistan's second most populous city), has a 60-bed psychiatric inpatient unit with an ongoing inpatient occupancy rate of around 60–70%. There are a few reasons that inpatient beds are not 100% occupied. Many families travel long distances and leave behind jobs, other family members, and social obligations to bring the patient to the hospital. Once admitted, a family member has to stay with the patient for the duration of his or her hospital stay (between two and five weeks), which results in significant disruption of their home life. Conditions in public hospitals are basic, with wardrooms that house 6–8 people, many acutely psychotic or agitated, in each. The rooms may have poor hygiene and sanitation, and very little, or no, climate control. For these and many other reasons, families often prefer outpatient treatment to inpatient admission. The situation is similar in most public teaching hospitals that cater to the segment of the population in the lower socioeconomic strata, including the rural poor. Finding an inpatient bed for an acute emergency is, therefore, not a problem.

For those who can afford it (and who prefer slightly more “upscale” surroundings), an inpatient bed can usually be found in one of several small, privately owned

inpatient hospitals in the larger cities. The demand for these inpatient beds remains high [24]. In general, inpatient admissions are not a problem for those who need it.

In cases in which the family and/or the patient does not wish inpatient treatment, the treating psychiatrist will usually recommend a course of medications with frequent visits to the clinic in the initial acute stage while keeping the option of inpatient treatment open if all else fails. This can be a problem for patients and their families from rural areas who may have to travel long distances to come to the clinic. Generally, the patient or family decides whether or not to admit the patient. On occasions, patients who are not acutely ill may be admitted due to an inability to visit the clinic frequently for continued outpatient treatment. Patients can be discharged to their homes with long-term follow-up after a suitable period of observation.

The same model of care applies to patients presenting with addiction-related mental illnesses (substance intoxication or withdrawal, substance-related mood or anxiety symptoms, or substance-related psychosis). Some private clinics and hospitals do advertise themselves specifically as treatment centers for substance abuse; however, in practice, these facilities suffer from the same shortcomings as the rest (lack of trained staff and appropriate services).

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## 24.4 Patient and Staff Safety Concerns

Recently, psychiatrists and other mental health professionals and advocates have attempted to engage in conversations with the public to emphasize the importance of professional treatment for patients with mental illness; their rights and the rights of their families; and the responsibility of society and institutions at large to address mental health in humane and compassionate ways. These efforts include minimizing the stigma surrounding mental illness by educating the public through articles in mass media and seminars [25].

Despite attempts to systematize laws and regulations, the biggest barrier that psychiatrists face in Pakistan is the actual implementation of these laws [26]. In emergent cases, there are no existing or identified policing or social welfare authorities to help psychiatrists.

Patients' families face similar obstacles, with no identified agencies for psychiatric emergencies such as acute agitation. Police will not assist family members transporting patients to EDs or clinics for treatment since they do not consider it part of their duty. Therefore, it is left to family and relatives to transport aggressive or psychotic patients, sometimes across long distances.

As demonstrated earlier in this chapter, there is a significant, nationwide disparity in access to available services and the utilization of treatment. Moreover, families often perceive these treatments as ineffective. It is not uncommon for family members to manage mental illness on their own, using prolonged periods of physical confinement as treatment. This may involve locking patients in rooms or even

tying them up with ropes or chains [27]. As a result, the mentally ill are particularly susceptible to violations of human rights, abuse, and neglect.

Additionally, the staff at both public and private treatment facilities have no training in how to safely manage acutely agitated patients. This can result in situations in which both patients and staff can be at risk of serious injury during a crisis [28].

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## **24.5 Personnel and Staffing: The Psychiatric Emergency Services Team**

A large burden of providing care for an acutely ill patient rests on the family due to the lack of emergency psychiatric service teams that are common in the US and other Western countries. In the US, these teams typically consist of a caseworker who may make home visits regularly; a therapist who may be a psychologist or social worker; a psychiatrist; a psychiatric nurse or nurse practitioner; and in many community mental health centers, a crisis team, typically staffed with social workers and therapists who do community crisis screenings of patients at local EDs and police stations. Additionally, the legal system in the US can back the crisis team with a court order for treatment of the acutely ill, and law enforcement personnel can safely carry out such court orders.

While Pakistan's Mental Health Ordinance (discussed later in the chapter) does make provisions for some of these types of facilities and personnel, it has not been implemented or enforced and only exists on paper. Although psychiatrists, psychiatric nurses, and psychologists are available on-site at many of the large public hospitals during working hours, and at some of the smaller private clinics at certain times, social work as a discipline is rudimentary at best in Pakistan. The responsibility of social workers is often borne by the patient's family. Similarly, the legal system and law enforcement play little to no role in emergency psychiatric treatment unless the patient commits a crime; in these cases, patients are usually processed through the criminal justice system rather than through a hospital or clinic. There is no such thing as a crisis team that can assess a patient at their home, an emergency department, or a police station. As mentioned above, if the patient is brought to the ED in a public hospital during regular working hours, they can be assessed by a psychiatric resident or trainee, in collaboration with a faculty member (provided that the ED staff send out a call). Most private clinics and hospitals have the facility to send out a small team of (mostly untrained) employees that may or may not be accompanied by a nurse to pick up acutely ill patients from their homes at the request of family members without *any* legal authorization or court order. This practice exposes patients to gross violations of their civil rights. It is common for patients to be forcibly detained in private psychiatric hospitals because of disputes with family members over money or property. Once detained, they have little legal recourse with which to plead their case [29].



## 24.6 Considerations for Coordination of Care

It would appear obvious that emergency psychiatric care currently in Pakistan exists separately from medical and surgical care. Even in the large, public hospital EDs where psychiatric patients regularly present in crisis, there is little understanding of how medical, neurological, and surgical illnesses can overlap with psychiatric illnesses. One of the reasons for this deficiency, as already outlined in this chapter, is that there is no separate psychiatric ED in the majority of the large public hospitals. Additionally, there is no regular psychiatric coverage in the EDs, even during normal working hours. Various medical and surgical trainees and faculty working in the ED are untrained in psychiatric illness, and thus, ill-equipped to provide treatment.

Suicide attempts regularly present to the ED of Pakistan's biggest and oldest hospital, Mayo Hospital, in Lahore. These individuals are often young, unmarried girls, mostly from poor families in rural areas who present after ingestion of various substances. The two most common substances are the highly toxic aluminum phosphide, known colloquially as "wheat pill" [30] since it is commonly used as a fumigant for stored cereal grains, and corrosive household chemicals. Wheat pill poisoning causes profound shock and multi-organ failure, thereby rendering it fast-acting and often fatal, while the ingestion of corrosive household chemicals can result in severe chemical burns in the mouth, esophagus, and GI tract, which can lead to permanent disability [31]. Despite the seriousness of these attempts, most patients, if they survive, are discharged home with no psychiatric referral or assessment. One of the authors has firsthand experience of multiple cases of corrosive ingestion treated as outpatients for long-term gastrointestinal complications without a psychiatric evaluation. In one instance, a young woman who overdosed and was subsequently intubated only received psychiatric treatment because her sister was a trainee at the same hospital and called the psychiatry team herself. In this particular case, the patient went on to make a full recovery. The situation is worse in private hospitals, which have no psychiatric coverage available whatsoever.

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## 24.7 Health Care Funding and Resources

Even though mental illness is a major contributor to deaths and disabilities, resources allocated to mental health in the national health budget of Pakistan are minimal. This is on par with other LMICs where the impact of mental illnesses on health and the economy is rarely analyzed [10]. Another factor in LMICs is the skewed distribution of health care resources, including resources for mental health, which are almost uniformly most heavily concentrated in urban areas. A recent paper [12], the first of its kind, analyzed the economic burden of mental illness in Pakistan. The authors concluded that mental illness poses a huge economic burden, 37% of the total economic burden, and accounts for up to 48% of productivity losses. This is due, in part, to delayed diagnosis and treatment. The authors recommended that Pakistan should equally prioritize mental illness with other non-communicable diseases (NCDs) as recommended by the WHO and integrate mental health into

primary care. They also recommended further studies on the economic impact of mental illness to guide future economic policy planning.

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## 24.8 Mental Health Legislation

Pakistan's mental health policy and mental health plan was last re-examined in 2003, while the disaster and emergency preparedness plan for mental health was last modified in 2006 [8]. The Pakistan Mental Health Ordinance, Pakistan's first piece of legislation relating to mental health, was formulated in 2001. The ordinance focused on issues regarding the accessibility of mental health care, rights of patients and those who use mental health services, and the family and caregivers. The legislation legally defined competency, capacity, guardianship, and voluntary versus involuntary treatment, and explored mechanisms to oversee involuntary admission and treatment plans, including areas overlapping with law enforcement and judicial agencies. Procedures for professional and facility accreditation, and procedures to execute the provisions of mental health legislation were also proposed [15]. A national mental health authority was planned to provide governmental advice on legislation and mental health policies with better service planning, coordination, and management while overseeing the quality of mental health services; however, such a system never materialized in actual practice.

In 2010, Pakistan's parliament passed the 18th amendment to the Constitution, which dissolved many essential functions to the provinces [32], including matters of health and mental health. In 2017, the southern province of Sindh (which includes Pakistan's largest city, Karachi) became the first, and only, province to establish a provincial mental health authority [33]. Pakistan's largest and most populous province, Punjab, still lacks a provincial mental health authority. In the absence of such a body, no implementation of the Mental Health Ordinance, originally enacted in 2001, has been possible.

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## 24.9 Education

All medical education in Pakistan is overseen and regulated by the Pakistan Medical and Dental Council (PMDC), the national body tasked with the certification and licensing of medical professionals. Postgraduate training and education, including training psychiatrists, was traditionally the purview of the College of Physicians and Surgeons of Pakistan (CPSP), the central examining and certifying body for medical specialists established in 1962. CPSP training and certification is still the gold standard for post-graduate medical education in Pakistan, although CPSP itself does not manage any hospitals or post-graduate training institutes. Psychiatric post-graduate training in Pakistan is a four-year program carried out in CPSP-accredited colleges, universities, and hospitals all over the country. At the end of four years of training, trainees have to pass both a written and an oral exam to be certified as Fellows of the CPSP (FCPS). The designation of Fellow means that the individual

is a specialist and can register as such with the PMDC. This four-year training period also includes continuous, ongoing assessment, and periodic, internal and external exams. All trainees are also expected to complete a CPSP-approved research project before completion of their training [34]. CPSP also offers 1-2-year training programs in psychiatry. The purpose of these programs is to train psychiatric specialists to serve in primary- and secondary-care facilities in smaller cities and rural areas. In the last two decades, individual medical colleges and universities have also begun offering post-graduate training programs in various medical specialties, including psychiatry. The MD (Doctor of Medicine) program in psychiatry is similar to the FCPS program and offers the MD degree upon completion, which is recognized as a post-graduate degree by the PMDC. Each institution runs its MD program, although the curriculum for the programs is based on the curriculum designed by CPSP for its FCPS trainees. All MD trainees are expected to complete a research project before completing their training.

In actual practice, FCPS and MD trainees work and learn side-by-side in the same hospitals.

Except for a few hospitals such as the Aga Khan Hospital in Karachi, psychiatric training in Pakistan does not include any specific training in emergency psychiatry, and most psychiatric trainees do not rotate through EDs [19]. There are significant lacunae in the training of most post-graduate trainees in Pakistan [35]. Their exposure to psychiatric emergencies is limited to acutely agitated, intoxicated, manic, or psychotic patients who present at the psychiatry outpatient clinic or similar presentations for inpatients.

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## 24.10 Quality Initiatives and Quality Assurance

Emergency psychiatric services need quality improvement initiatives in areas about treatment access, the sheer volume of patients that need treatment, and the paucity of psychiatrists and other mental health providers, especially in peri-urban and rural areas. Even in urban areas, busy public hospitals are often inundated with patients during normal working hours, many of whom have traveled great distances to be seen. In Pakistan, unlike in the United States and other Western countries, there is no requirement for hospital or clinic certification according to any national or international standards. There is no institution similar to the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), so any quality improvement initiatives put in place are solely at the discretion of the administration of the relevant hospital or, very rarely, the provincial government. As such, improvement in the quality of care remains an ongoing problem.

One initiative worth mentioning concerning mental health is the WHO's Mental Health Gap Action Program (MHGAP), whose objective is to expand services for the triad of mental, neurological, and substance use disorders in low- and middle-income countries [36]. Pakistan has recently begun implementing a pilot MHGAP program under the auspices of the WHO's Eastern Mediterranean Region (EMRO) in select areas [37].

## 24.11 Summary

Pakistan, with its large and rapidly growing population, faces an acute shortage of mental health services including emergency psychiatric services. The available services remain fragmented and rudimentary, and are usually only available in the larger urban areas. The need for comprehensive mental health services in Pakistan is high and continues to grow exponentially. The current mental health service structure is rudimentary at best and struggles to cater to those who need it the most; therefore, a large number of those in need fall through the cracks. While increased funding and resources are critical for further development of services, improved care-coordination between psychiatry and other medical specialties is also necessary to provide appropriate acute psychiatric care. To broaden the coverage net, it is crucial to integrate mental health services into primary care using a model like MHGAP. Further, residency training experience needs to include psychiatric emergencies in the ED, especially in public hospital settings, as well as more exposure to community psychiatry. Finally, it is crucial to note that important revisions in mental health legislation and more effective implementation are sorely needed.

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